MEDICARE HEARINGS ON CONTROLLING COSTS AND IMPROVING CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

FEBRUARY 6, 7, AND 10, 1995

Serial 104–19

Printed for the use of the Committee on Ways and Means

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ISSUES REGARDING EXTRAORDINARY GROWTH IN CERTAIN MEDICARE COSTS

MONDAY, FEBRUARY 6, 1995

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE — CONTACT: (202) 225-3943
January 30, 1995
HL-3

THOMAS ANNOUNCES THREE HEARINGS ON MEDICARE ISSUES

-Focus on Controlling Costs and Improving Care-

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee next week will hold three hearings on Medicare related issues.

The hearings will examine issues related to controlling growth in Medicare costs; income-relating Medicare Part B premiums; and improving care through Medicare reform and innovation.

The first hearing on issues regarding the growth in certain Medicare costs will be held Monday, February 6, 1995, at 10:00 a.m. The second hearing on Medicare part B premiums will be held on Tuesday, February 7, at 2:00 p.m. The third hearing on Medicare reform and innovation will be held on Friday, February 10, at 10:00 a.m. All three hearings will be held in the main Committee hearing room, 1100 Longworth House Office Building.

Invited witnesses will include representatives from the Administration, Physician Payment Review Commission, Prospective Payment Assessment Commission, General Accounting Office, a variety of health experts, and other interested parties. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Several areas of the Medicare program have grown at alarming rates over the last several years and may represent significant fraud and abuse. These areas include spending for post-acute services furnished by skilled nursing facilities, home health agencies, and rehabilitation and long-term care hospitals. For example, real average growth rates per enrollee for nursing home care have risen 39.3 percent from 1991 to 1993. Similarly, home health services per enrollee have grown at 31.1 percent over the same period.

The Medicare Part B Supplementary Medical Insurance (SMI) Trust Fund finances primarily physician and outpatient services. The Part B trust fund is financed by premium payments from enrollees and by general revenues from the U.S. Treasury. SMI is voluntary and all individuals electing the program receive a 75 percent premium subsidy regardless of their income.

Medicare is currently engaged in some innovative programs providing beneficiaries access to managed care. These include Risk Contracts, Medicare Select, Cost Contracts, Health Care Prepayment Plans, Group Prepayment Plans, and Social Health Maintenance Organizations. Enrollment of Medicare beneficiaries in these managed-care alternatives has lagged far behind enrollment in the private sector. Several features of these programs act as impediments which discourage some plans from participating and deter beneficiaries from enrolling.

In announcing the hearing, Chairman Thomas said: "There are many successful, private-sector programs that can serve as models for improving the Medicare system. This series of hearings will explore several of these programs. As we lay the foundation for the work the Subcommittee will engage in over the next several months, we will examine how we can provide quality services while slowing the rate of growth in medicare spending."

FOCUS OF THE HEARING:

The first hearing will focus on areas of alarming cost growth for the Medicare program, with an emphasis on underlying causes and recommendations to address these growth rates. The second hearing will review issues related to fairness under the Part B premium. The third hearing will review existing Medicare managed-care programs, focusing on their effectiveness, beneficiary satisfaction with the programs, impediments to broader utilization of the programs, and ways in which the program can incorporate some of the more promising private sector innovations.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Friday, February 17, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * * * *

*** NOTICE -- CHANGE IN LOCATION ***

ADVISORY
FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 6, 1995
No. HL-3-Revised

CONTACT: (202) 225-3943

THOMAS ANNOUNCES CHANGE IN LOCATION FOR HEALTH SUBCOMMITTEE HEARING ON FRIDAY ON MEDICARE REFORM AND INNOVATION

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare Reform and Innovation which was originally scheduled for Friday, February 10, 1995, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building, **will be held instead in Room B-318 Rayburn House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee press release No. HL-3, dated January 30, 1995.)

******

Chairman THOMAS. The subcommittee will come to order.

Today, the Ways and Means Health Subcommittee begins a series of three hearings on Medicare policy, which will continue on Tuesday and conclude on Friday. In this morning's hearing, we will examine Medicare benefits, growth in Medicare costs and other areas of provider public policy which may require assignment.

The second hearing on Tuesday, the 7th, will focus on the issue of income relating to Medicare part B premiums.

The third hearing on Friday, February 10, will concentrate on the potential of managed care for Medicare beneficiaries.

These hearings reflect the manner in microcosm, in essence which the Health Subcommittee will approach Medicare policymaking in the 104th Congress. We should continue the work of reforming the current system, but we must also now look to the future to transforming Medicare in order to bring it into the nineties and prepare for the next century.

First, as we will do in this hearing, we should closely examine the current fee-for-service side of Medicare. Where there are changes in law that can be made in the context of the current benefit and payment structure to curb costs and inappropriate uses of services, we should obviously take those steps. We have a responsibility to assure the beneficiaries and the taxpayers that a fee-for-service Medicare payment policy is designed with clear incentives to promote quality and cost-effective care at the best price that can be obtained.

Then, on Tuesday, we will examine the financing of Medicare part B, which, as you know, is funded by beneficiary premiums and the Nation's general fund. This hearing on income relating to part B will answer two simple questions: Should the taxpayers who now pay for almost 75 percent of the Medicare cost part B benefits subsidize Americans who can well afford to pay more of that cost? And if the Congress should income relate part B premiums, what are the design issues raised by such a change in the law?

Under today's program, if Donald Trump reaches 65, he will receive the same 75-percent subsidy as other Americans under part B, whether they live from Social Security check to Social Security check or on top of the tower. This fact cannot be justified to the average taxpayer. So we should examine income relating part B of Medicare.

This reform should be considered as the subcommittee discusses other incremental revisions of Medicare policy that will increase the financial integrity of the program without undermining its promise of protection for senior citizens.

However, incremental change in payment policy or financing, as we know, is not sufficient to maintain the promise of Medicare. We need to assure all Americans that they will have health care when they get older.

Fortunately, it is not written in stone that the structure of the Medicare program has to remain the same for all time. The fact is, in contrast to health insurance coverage in the private sector, which has evolved in recent years to meet the needs of customers concerned about both the cost of care as well as its quality, Medicare continues to operate basically under midsixties rules.

Of course, the Congress has refined the Medicare payment policy in ways that have had some beneficial effects. But the program remains fundamentally a fee-for-service health plan with incentives that increase volume and with little or no assurance that care will be cost-effective or high quality.

And that is why the third hearing on Friday in this series is so important. It will begin to address the issue which reflects the priority question for this subcommittee in 1995. How do we transform Medicare to improve it for the beneficiaries while making the program relevant to this decade and beyond? So Friday's hearing will focus on managed care in Medicare, both the use of health maintenance organizations and Medicare Select.

But this is only the start. We will begin a complete exploration of the models that the private sector may have to offer as examples for Medicare reform. The tinkering with Medicare payment policy over the last decade and a half was done in good faith. Nevertheless, we must now move on to ask more fundamental questions about the structure of Medicare if it is to survive.

It is our responsibility, this subcommittee, to make Medicare all it can be. However, to enable Medicare to continue into the 21st century, we must begin to reform it now. Otherwise, the structure that is in place will lead to bankruptcy of the system, and future Congresses will not be able to keep the promise of health care made to this Nation's elderly or will have to do so in such a drastic way in a short time that the popular support for Medicare may be greatly undermined.

And, with that, I will yield to the ranking member.

Mr. STARK. Thank you, Mr. Chairman.

These are indeed significant hearings, the stated purpose of which I thought was to identify areas of growth in the Medicare program that may represent significant fraud and abuse. And I congratulate the Chair on focusing on this, and we are ready to lend a hand.

In March 1993, I introduced the National Health Care Anti-Fraud and Abuse Act to combat health care fraud in the entire American health system. Mr. Gingrich forbade the Republican committee members from supporting those efforts, but I again encourage the members of the Republican Party to again seriously consider these initiatives.

I will provide you, Mr. Chairman, with an additional list of antifraud and abuse items that I hope will prove useful.

We could adjust the figure with which we reimburse Medicare HMOs. We know that the 1995 percent rate is somewhere between 6 and 28 percent too high. Hospital-owned DME and home health services I think bear close scrutiny. And we can show that banning hospital referrals to home health agencies that they own might be a productive way to save money.

There is physician office abuse and other services we might look at. And there is a lot of waste in the transportation service that we might look at.

We must, to combat fraud and abuse, be willing to invest in its enforcement. Over the past year, the Inspector General reports increased complaints of fraud and abuse in the neighborhood of 30 percent. Last year we passed legislation that would have expanded the resources available to the Inspector General by establishing a fund dedicated to increased antifraud efforts and the fund to be replenished with the dollars secured from successful health care fraud enforcement. If we are serious about stopping fraud, we must be willing to make this kind of investment.

I would like to talk about what we should not do in the area of health care fraud and abuse.

I don't think we should kid ourselves that even complete elimination of fraud in the Medicare program will achieve the drastic cuts that some in the majority are calling for. In fact, the Office of Inspector General, and the GAO, both concluded that Medicare, while not immune from thieves and scalawags, is several steps ahead of private insurers in preventing fraud.

I certainly hope it is not the intention of the Chair to use the label of fraud and abuse to describe efforts to chop away at Medicare—a tremendously successful program that provides health security to 99 percent of our over-65 population.

The Democratic members of this committee will oppose all changes to Medicare that do not strengthen the program directly or remedy defects in the broader health care system.

It is apparent that there is newfound interest in making contracts with the American people. But for 30 years, we have been working to uphold a true contract with America—that is Medicare. We have not and will not agree to breaking the Medicare contract of health care security to our Nation's disabled and elderly in order to finance today's Republican tax cuts for the wealthiest.

The Republican Contract calls for taking $48 billion out of the Medicare Hospital Insurance Trust Fund in order to pay for tax cuts to the wealthiest 15 percent of the seniors. I believe that is wrong. If we wish to combat fraud against the Medicare program and the American people, that proposal should be removed now.

The last comment is that, as we speak, the room is full of lobbyists who would like to increase the abusive practices by repealing one of the strongest propatient, antifraud laws.

In 1989, under George Bush and with the active participation of Harry and Louise, who now serve the industry and the majority of this committee, Congress prohibited physicians from referring patients to clinical labs. But unfortunately, it got dubbed the Stark law; and it was, in fact, the Bush law.

Studies show that patients of referring physicians who own or invest in clinical labs receive 34 percent more unnecessary testing from those clinical labs than when no ownership interest exists. In 1993, patients were further protected through an expansion of the list of designated services.

If we are serious, Mr. Chairman, about protecting patients and the integrity of the Medicare program from fraud, we will not acquiesce to those who are begging us to repeal the antireferral laws.

Thank you.

Chairman THOMAS. Any other members may submit comments so we may begin this committee hearing.

[No statements were submitted.]

Chairman THOMAS. We have before us Dr. Eisenberg, who is the Chairman of the Physician Payment Review Commission; Dr. Stuart Altman, who is the Chairman of the Prospective Payment Assessment Commission, and has been since its inception.

We ordinarily would tell you your written statement would be made a part of the record and that you have 5 minutes to proceed as you may see fit. Given the positions that you have and the information that you are going to provide in terms of historical overviews of the existing Medicare payment mechanisms, problems arising from these mechanisms and recommendations for addressing these problems, we might be a bit more lenient on the time.

Dr. Eisenberg, if you would like to begin.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN LEROY, ACTING DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman, members of the committee.

I am pleased to represent the Physician Payment Review Commission today with the committee to discuss growth in Medicare expenditures for physicians' services and its causes; and I am accompanied by Lauren LeRoy, who is the Acting Director of the Commission.

As Chair of the Physician Payment Review Commission, I will focus on the issues relating to physician payment as they contribute to the increase in Medicare costs, and I will divide my comments up into two parts. First, I will talk about mechanisms that can be used to reduce future spending; and, second, options for legislative changes that are going to be needed to put those mechanisms in place.

First, we ought to ask the question what kind of growth in expenditures are we talking about today?

Between 1992 and 1993, Medicare growth was 11.5 percent. That was greater than the 8.6-percent growth that we saw in the private health insurance market. And if we focus on physician services, we can see that between 1986 and 1991 the annual rate of growth was 10.5 percent for physician services. But then between 1991 and 1993, that rate of increase in physician services expenditures dropped. It dropped to 3.8 percent. But even at that reduced rate the rate of increase in physician expenditures was greater than that of gross domestic product per capita.

From the preliminary data that we have, the Physician Payment Review Commission has suggested that the growth rate in 1994 and in 1995 will likely be higher than the 3.8 percent that we have experienced between 1991 and 1993. So the problem seems to have abated some. We are not sure at this point, whether that abatement is temporary.

Why did we experience the growth in Medicare physician expenditures in the first place? The population of Medicare beneficiaries has increased, and that is one of the reasons. About 1.5 to 2 percent of the increase in physician services expenditures has been due to that factor, the increase in the number of the beneficiaries each year.

Second, there has been an increase in the volume of services. That is the most important factor today. Between 1988 and 1992, a period of time when there was a 7.7-percent increase in physician expenditures, the volume increase accounted for 6 percent of that 7.7 percent.

The increase in the number of beneficiaries, as I said, was about 1.5 to 2 percent. The aging of the population accounted for only 0.1 percent, and the remainder was due to increases in prices, a very small increase during that period of time.

Much of the reason for that is because the focus of the Congress during the past few years has been on fees and limiting the fees in the Medicare system for physicians. Through the Omnibus Budget Reconciliation Act of 1989, Medicare fees were adjusted to address many of the problems that contributed to that rate of increase during the preceding years.

And, like any other prudent purchaser, Medicare decided that it would not accept the historical charges that physicians were rendering. That it, like any other prudent purchaser, like a health maintenance organization, would establish fees that were based on what both it could afford and on what seemed to be able to provide reasonable access to high-quality care for beneficiaries.

The PPRC has worked with the Congress and will continue to work with the Congress to improve the way in which this fee schedule has made Medicare a more prudent purchaser. But our preliminary data suggests that the Medicare payment level today is about 70 percent of the payment level that exists in the private sector. Therefore, we believe that the focus in the future should not be so much on the fees but rather on the volume of services that is provided by physicians in the Medicare system.

And Medicare's primary control of the volume of services provided is in the Medicare volume performance standard, which was also enacted in the Omnibus Budget Reconciliation Act of 1989.

Now, this MVPS, Medicare volume performance standard, gives the Congress two tools. One, is it gives it a tool for budgeting. Two, it gives the Congress a tool that offers the physician community a collective incentive to try to reduce the number of inappropriate or unnecessary services that are provided.

So this MVPS, this volume performance standard, gives the physician community a target rate of growth that is set by Congress yearly after consultation with our Commission and with the Secretary of Health and Human Services.

The key here is this: That the volume performance standard is established and payment levels are adjusted up or down depending on whether aggregate expenditures by the physician community achieve that goal. It is a method that is similar to that which is used by some managed care organizations which offer physicians an incentive to meet a certain target or they do not receive the full price that they were expecting.

So, in essence, this MVPS, the Medicare volume performance standard, is seen by many people as sort of a bargain between the Congress or the Health Care Financing Administration and the physician community. The bargain is we will pay you higher fees if you can keep your volume increases down. But if the volume increase goes up, you are going to get a lower fee.

Now, the facts of the past 2 years with the decrease in the rate of increase in physician expenditures makes it seem as if the VPS mechanism has worked reasonably well. And, in fact, the VPS mechanism has been tied with this resource-based relative value scale which was also introduced in 1989, and the combination seems to have helped to reduce the rate of increase, at least in the past 2 years.

In fact, the resource-based relative value scale seems to have been picked up by the private sector, including about one-third of managed care organizations. A large number of States for their Medicaid plans have picked up the concept, using the resource-based relative value scale as they move to new ways of paying physicians.

But there are still very serious problems in holding down the rate of increase in volume. Let me just emphasize again, that is where the focus has to be.

One of the problems with the Medicare volume performance standard is that there are currently three different updates with what we believe to be a flawed methodology for calculating what those updates ought to be. That has led over the past 5 years—or 5 years of updates—1992, 1993, 1994, 1995—to a cumulative 18.37-percent increase in fees offered to physicians overall but large differences among groups of services rendered by those physicians.

Surgical services have had an increase of 29.7 percent; primary care services an increase of 19.6 percent; and other nonsurgical services an increase of 13.8 percent. So there are large differences in the rate of increase in the conversion factor, which is the dollar amount that is multiplied times the resource-based relative value scale to come up with the price that doctors are paid.

So as we consider opportunities for the future, I want to divide them into two parts: First, for the current Medicare plan, the current paradigm of Medicare, we believe that improvements can be made in the volume performance standard that would help to address the topic of today's hearing, that of volume of services on the physician side. We believe that these corrections in the VPS could help to decrease the rate of increase in the volume should it start to increase again. And, as I mentioned, our early data suggest that it likely will.

But, second, we believe more fundamental changes can be considered by the Congress that would change the way in which the Medicare program is structured in order to allow beneficiaries more access to managed care plans, to changes that have occurred in the private sector, and to enable Medicare beneficiaries to participate in those new programs in a way also that would enhance the willingness of those plans to participate in Medicare.

Now, as always, PPRC's position is as follows: That if Congress decides that it wants—needs to reduce spending, our job, as we interpret it, is to help you to accomplish those savings in a way that is consistent with the long-term policy goals of the Medicare program. So let me divide my remaining comments into changes in the fee-for-service Medicare plan and then changes that might be considered under a managed care approach.

First, under the fee-for-service plan, we believe that we should focus on the conversion factor, not on the relative values. That by focusing on the conversion factor that changes in the relative values can remain consistent with the principles of the relative value system and not threaten the integrity of that scale, which, as I mentioned, has been picked up by the private sector as a reasonable model for paying physicians.

Our major point is this—that there are serious technical problems with the way in which the default formula calculates what the update for physician payment ought to be. Our preliminary analyses tell us by the year 2003 with the current default formula that physician payment may well be—in fact, is likely to be lower than the payments today, even correcting for inflation. And that is a result of the technical problems that exist in the current mechanism for calculating the VPS.

The reason for this is because there is an automatic 4-percentage point reduction that is embedded in the formula for the Medicare volume performance standard; and this automatic 4-percentage point reduction, which might have made sense when the rate of increase was 10 or 11 percent but does not seem to make sense when the rate in increase in physician expenditures is 3.8 percent, is embedded in the formula. That 4-percentage point reduction, plus the anticipated lower rate of increase, will make it difficult, very difficult for the Congress to achieve additional savings by reducing physician payment in the future if that 4-percentage point default—4-percentage point factor in the default is not corrected.

So we would recommend—PPRC would recommend that we replace this formula with a formula that is linked to the projected increase in the gross domestic product so that increases in the Medicare program are affordable, given the increasing wealth of the Nation.

Second, that we eliminate the separate payments and the separate performance standards, the separate updates that are used for different groups of services or at least change the baselines upon which those calculations are made or, as one other alternative, make the changes only for 1 year.

Third, that we use a cumulative target so that there is a cumulative comparison of actual expenditures and targeted expenditures rather than just doing this on a year-by-year basis, which causes us, we believe, to chase our tails.

And then, finally, we believe that there should be a limit to the size of the increases in physician payments just as there are currently limits to the size of decreases in physician payments.

Now, finally, with managed care, we believe that changes can be made in the Medicare program to make it possible for beneficiaries to enroll in managed care programs and to have a wider choice of plans that they could enter.

Currently, only 9 percent of Medicare beneficiaries are in managed care programs. There are a variety of reasons for that, but a key one is because the managed care programs don't find it beneficial to participate in managed care.

There are wide geographic variations in the prices available to the HMO. There is a tremendous amount of volatility from county to county and from year to year. There is inadequate risk adjustment, and there is unrestricted movement for the HMO, if it decides that it is not doing well with the calculated cost that is made available, to a cost-plus formula or a cost-based formula. And 25 percent of HMOs are still operating under cost-based reimbursement.

Given that scenario, we don't think that, with the current formulation, Medicare will be able to see as large an increase in the participation of its beneficiaries in HMOs as the Congress would likely want to see. With changes, we believe that more opportunities would be available to the beneficiary, including Medicare Select and others, to give the beneficiary more choice.

And, therefore, the PPRC suggests that the Congress consider four options:

The first option is to consider a competitive pricing system for managed care that would allow more creativity on the part of the managed care plans and a more competitive mechanism for establishing a price for the Congress and for the Health Care Financing Administration. Now, this competitive pricing mechanism could use market mechanisms to establish payments. It could use a bidding process, for example, so that a price could be set through a bidding process.

Individual beneficiaries then could choose whether they wanted to go to a higher cost plan, in which case they might be required to pay the difference between what Medicare would pay and what they would choose to—what they would need to pay in order to enter that higher cost plan.

So we would recommend that the Health Care Financing Administration be given the authority to introduce competitive bidding in markets that have the best chance of success, that is, those areas where there is a competitive managed care market and then expand this plan as it is possible to do so as managed care becomes more competitive in other regions of the country.

Second, we believe that the AAPCC, the average adjusted per capita cost, the way in which Medicare calculates what it will pay the HMOs, the managed care programs, needs to be changed. It needs to be changed so that it includes multiple counties, so that it considers different input costs for the various managed care programs in different parts of the country, and so that it improves the risk adjustment capacity of this program, thereby paying health maintenance organizations more appropriately in a system where competitive bidding is not being used.

So it is an alternative to the competitive bidding process or it could be embedded in the competitive bidding process, letting the AAPCC serve as a kind of benchmark for the bidding process.

Third, the PPRC is interested in considering the possibility of partial capitation demonstration projects. By that I mean that Medicare would offer the opportunity for a health maintenance organization to enroll beneficiaries with partial capitation, a part of the payment would be capitated, perhaps it would be blended with partial fee-for-service payment or cost-based payment to the HMO so that we could gradually move into a situation where the HMO felt more comfortable taking the risk that is incumbent in the Medicare risk contracting program, or alternatively risk corridors could be used for those HMOs.

And, finally, PPRC is concerned about the continued presence of the cost contracts in managed care and believes those cost contracts should be limited at least, if not eliminated.

Let me end by commenting on the fact that there are a number of other factors that influence expenditures in the Medicare system, many of which are part of the health care system in general.

The PPRC is convinced that the capacity of the health care system is too large. We have focused, given our focus on physician payment, on the physician work force. And we believe that, as the Congress reconsiders direct medical education payments to teaching institutions, that it ought to consider a national per resident amount rather than the widely variant amounts that are currently paid to hospitals.

We also believe that the direct medical education payment should encourage ambulatory education. This is an area where the Prospective Payment Assessment Commission has done a tremendous amount of thinking, as well.

So, in conclusion, Mr. Chairman, members, the Physician Payment Review Commission believes that there are opportunities for the Congress to achieve savings, both in the traditional Medicare fee-for-service plan but greater savings, perhaps, in moving Medicare to a system whereby beneficiaries would have a choice of Medicare plans which would include managed care opportunities, and we have offered you a number of suggestions about ways in which we might move in that direction. We look forward to working with you to try to develop these plans and to consider their feasibility.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG, M.D.
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss growth in Medicare expenditures for physicians' services and its causes. Since it was established by the Congress in 1986, the Physician Payment Review Commission has devoted a substantial portion of its work to issues related to physician payment under Medicare. Our work assisted the Congress in shaping the Medicare payment reforms enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA89). We have followed up on that work by monitoring implementation of those reforms and developing refinements to ensure that the policy meets its objectives of holding down the rate of expenditure growth, removing distortions in physician payment, and limiting beneficiary financial liability.

As this subcommittee considers reforms in the Medicare program and takes on the challenge of reducing the federal deficit, it is important to understand recent trends in program spending and the impact of past policies on growth in price, volume, and total expenditures. My testimony today first reviews those trends and policies. It then considers the mechanisms that could be used to reduce future spending and options for legislative changes that would be needed to accomplish those changes. Different strategies will be appropriate for the fee-for-service and managed care sectors. Moreover, any short-term steps should be consistent with the anticipated direction of more comprehensive reforms, particularly those that would permit Medicare to take advantage of the innovations in service delivery and payment that are now being used in the private sector. I will conclude my testimony by commenting on the relationship between physician supply and and expenditure growth and Medicare's role in financing graduate medical education (GME). The Commission has made budget recommendations concerning GME in past years and can offer some general advice in this area.

Let me also add that my comments reflect the Commission's evolving views as it shapes its 1995 *Annual Report to the Congress*. These recommendations will be finalized later this month. They will be transmitted formally to you as required by law at the end of March, but we will work closely with your staff before then to provide the assistance you need in shaping Medicare policy.

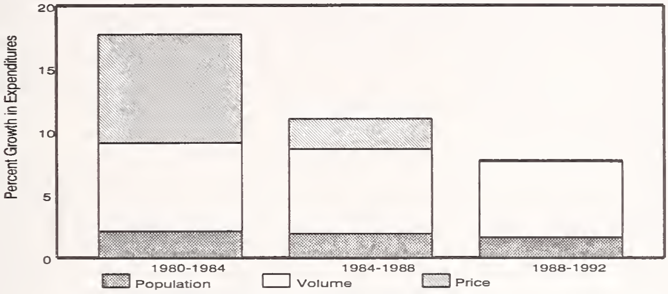
BACKGROUND: TRENDS IN EXPENDITURE GROWTH

Physicians' services account for about 50 percent of spending under Medicare Part B and in fiscal year 1994, amounted to $29.9 billion. After extremely high growth during the early 1980s, annual growth in expenditures for physicians' services has slowed considerably relative to the historical trend. Between 1986 and 1991, expenditures grew at an annual rate of 10.5 percent. By contrast, between 1991 and 1993, estimated expenditure growth slowed to an average rate of 3.8 percent. Even at this level, however, growth in Medicare expenditures exceeds growth in the gross domestic product (GDP). Moreover, preliminary data suggest that the rate of expenditure growth for 1994 and 1995 is likely to rise.

Medicare expenditures as a whole are outpacing growth in private sector health expenditures (11.5 percent growth in Medicare versus 8.6 percent growth for private health insurance expenditures between 1992 and 1993). Growth in Medicare physicians' services, however, was substantially lower than growth for other types of services financed by Medicare.

Increased Medicare outlays can result from two sources: increases in payment rates and increases in the quantity or mix of services provided. Increases in services can be separated further into two components: those due to growth and aging of the population and those due to changes in the practice of medicine. While population growth is often mentioned as being a major cause of rising physician expenditures, in fact, its impact has been relatively small with Medicare beneficiaries growing at between 1.5 percent and 2 percent annually [Figure 1]. But, if the rate of expenditure growth declines, as it did in recent years, increases in the Medicare population become a more significant factor in overall spending growth.

Figure 1. Growth in Medicare Physician Expenditures (for Aged Enrollees), by Component, 1980-1992



SOURCE: 1994 Annual Report of the Board of Trustees, Federal Supplementary Medical Insurance Trust Fund.

The distinction between growth attributable to price and growth attributable to volume is important for understanding past congressional action to slow expenditure growth. During the 1970s and 1980s, the primary policy levers to restrain Medicare expenditure growth were restraints on price, either through across-the-board fee freezes or via fee cuts for procedures that the Congress specified as overvalued. The latter were intended to be consistent with the direction of payments under the Medicare Fee Schedule established as a part of physician payment reform in OBRA89. First implemented in 1992, the fee schedule's purpose, however, was not to constrain prices but to eliminate distorted incentives and inequitable payments across specialties, services, and geographic areas.

Constraints on prices resulted in slower expenditure growth and were consistent with the goal of moving fees towards resource-based payment. During the late 1980s, when fee constraints were in place, volume became the principal force driving up expenditures for physicians' services; from 1988 to 1992, payment rates accounted for about 0.1 percentage points of total growth in expenditures while the volume of services accounted for 6 percentage points of the 7.7 percent total growth in expenditures for elderly enrollees (Figure 1).

There are questions, however, about whether such constraints can hold down expenditure growth over the long term. Also at issue is how much Medicare fees can be reduced without jeopardizing beneficiaries' access to care. Medicare fees are now near 70 percent of what private payers now offer to physicians.

The Commission has long held that a direct measure to contain volume is needed to maintain program expenditures at a sustainable level. Medicare's primary mechanism for addressing volume growth is the system of Volume Performance Standards (VPSs), enacted as part of physician payment reform in 1989. The VPS serves two purposes. First, it is a budgeting tool that improves predictability in expenditures by linking payment levels to the growth in volume and intensity of physicians' services. Second, it is intended to serve as a collective incentive to the medical profession to find ways to reduce inappropriate care, such as developing and disseminating practice guidelines that promote cost-efficient practice styles.

Under OBRA89, a performance standard (essentially a target rate of expenditure growth) is to be set annually either by the Congress after consulting with the Commission and the Secretary of Health and Human Services or by a default formula specified in law. (In fact, the default formula has been used in most years.) Then payment rates are adjusted in subsequent years as actual expenditure growth exceeds or falls below these standards. Performance standards were first applied to physicians' services in 1990; fee updates based on how well physicians met these standards were first applied in 1992.

Although the Commission had recommended a single performance standard, OBRA89 created a system with two: one for surgical services and one for nonsurgical services. A third standard (primary care) was added under OBRA93 in response to concerns that growth in volume for technical procedures in the nonsurgical service category was depressing fee levels for primary care. Even though this has resulted in larger fee updates for primary care than under the two standard system, even higher updates for surgical services have resulted in distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct.

Beginning in 1992, volume growth slowed substantially. As a result, Medicare fee updates for 1994 and 1995 were much larger than had previously been anticipated (Table 1). The reasons for this slowdown in growth are unclear (as are the prospects for its continuation). Possible explanations include responses to the incentives created by the VPS and secular changes in the practice of medicine. The latter include slowed growth in technologies introduced during the mid to late 1980s such as cataract surgery and magnetic resonance imaging, and more efficient practice styles as a result of the increased penetration of managed care. Others suggest that low volume growth in recent years merely reflects its inherent volatility. In fact, the trend probably reflects a combination of these factors.

Table 1. Conversion Factor Updates for 1992 through 1995 (percentage)

Categories of Service[a]	1992[c]	1993[c]	1994[b]	1995[b]
All Services	1.9	1.4	6.8	7.7
Surgical	--	3.1	--	--
Nonsurgical	--	0.8	--	--
Surgical	--	--	10.0	12.2
Primary Care	--	--	7.9	7.9
Other Nonsurgical	--	--	5.3	5.2

SOURCE: Physician Payment Review Commission compilation of final updates from Federal Registers.

[a] A single update for all services was made in 1992, separate surgical and nonsurgical updates were required in 1993, and a separate update for primary care services began in 1994.

[b] Set by congressional decision.

[c] Determined by default formula.

PHYSICIANS' SERVICES: OPPORTUNITIES FOR THE FUTURE

Future efforts to limit Medicare spending for physicians' services may focus on either the fee-for-service sector, still the predominant form of payment under the program and the option chosen by over 90 percent of beneficiaries, or on expanding enrollment in managed-care plans in anticipation that such systems of care will be more efficient providers. Efforts to attain savings in the short-term, however, should not lose sight of structural problems that could impede achievement of policy goals in the long-term. Specifically, changes in the VPS are needed to ensure its ability to control the rate of volume growth should it begin to rise again, while changes in the method for paying managed care plans are needed to enhance their willingness to participate in the program. The Commission has some suggestions in each of these areas which would enhance program performance and help it capitalize on innovative changes in the health care market.

The Commission recognizes the difficult task the subcommittee will face in finding budget savings in physicians' services and we stand prepared to advise you on these issues.

Traditionally, the Commission has not commented on the overall magnitude of cuts in Medicare. Instead, we take as our assignment the following: if the Congress should decide to reduce spending, how can that be accomplished in a way that is most consistent with long-term policy goals.

Fee-for-Service

In the past, proposals have been offered to slow growth in spending through selective changes in relative payments for certain services (so-called overvalued procedures). While this was an appropriate strategy during the years of transition to a new payment system, making such cuts now would threaten the integrity of the resource-based relative value scale. This is a problem not only for Medicare but for the many private payers and Medicaid programs that use Medicare's relative value scale. Instead, payment policy changes should focus on changes in the conversion factor, which would decrease fees across the board, rather than on changes in payments for specific services.

Given the large fee updates awarded in 1994 and 1995, the Congress may be inclined to achieve budget savings by rescinding previous fee updates or by making further adjustments to the VPS default formula. It is the Commission's view, however, that technical problems with the default formula used in setting volume performance standards should be corrected first. This is because despite recent high updates in Medicare fees, the current policy in place will result in substantial reductions in the conversion factor over the next five years. In fact, conversion factors in 2003 are projected to be lower than when the policy was first implemented in 1992, even without accounting for inflation. Moreover, the existence of three performance standards is introducing serious distortions in payment rates.

Once these problems are addressed, then an across-the-board cut in the conversion factor could be considered as a means of budget savings. For example, the size of the cut could be set so it would be comparable to rescinding part or all of the 1994 and 1995 updates. If the Congress decides to take this approach, however, it should be mindful that it would widen the gap between the fees paid by Medicare and those of private payers. These issues are considered below.

Fixing the Default Formula. The current VPS system has several flaws. First under OBRA89, performance standards are determined in part by the historical trend in volume growth. At the time the law was written, historical trends were viewed as including some amount of inefficiencies and inappropriate care and therefore a decision was made to reduce the performance standard formula accordingly. Initially, deductions of one half of a percent were taken from the historical trend, phasing in over time to two percentage points. Under OBRA93, the deduction was increased to four percentage points.

The problem is that this deduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such reductions year after year.

The combination of the four percentage point deduction enacted in OBRA93 and a lower than anticipated volume growth rate may make it extremely difficult to get additional savings by reducing physician payment. Since it is unlikely that volume growth will fall four points below current levels, maximum deductions in fees are already expected to be taken beginning in 1998 and continuing through 2002.

The bottom line is that changes in the VPS default formula are urgently needed. To address this problem, the Commission recommends replacing the current formula (historical trend in volume and intensity minus four percentage points) with a formula linked to the projected growth of real GDP per capita. This would permit a reasonable rate of growth that is affordable over the long term.

The Commission also recommends two additional changes to limit further distortions in relative payments and to improve accuracy and accountability within the system. First, to ensure the integrity of the resource-based relative value scale, separate performance standards and updates for categories of services should be eliminated. If they are retained, they should be based on the trend in volume growth for each category as required by OBRA93, and differential updates should be in effect for one year only. As long as you have differential updates and allow the differences to be built into the baseline, you will distort relative payments.

Second, fee updates should be based on comparisons between total actual expenditures and total targeted spending since a base year. Under current policy, comparisons are made between expenditure growth and the performance standard for a single year. Missing the target in one year does not affect the update for the following year. A policy that makes comparisons between total actual expenditures and total targeted spending since a specified base year, on the other hand, accumulates year-to-year surpluses and shortfalls and applies them to subsequent years.

In addition, limits on the size of both reductions and increases should be established to lessen the volatility of fee increases and reductions. Currently, updates are limited to a 5.0 percentage point penalty if actual expenditures exceed the performance standard by more than 5 percent. No comparable limit constrains the size of increases. Symmetric limits of 5.0 percentage points should be used to prevent both extraordinarily high increases as well as reductions. These two changes combined will add full accountability for total expenditures for physician services while ensuring that annual fee updates are relatively stable and reasonable.

The Gap between Medicare and Private Fees. Medicare fees are currently near 70 percent of those paid by private payers. The gap between Medicare fees and those of private payers in 1995 is less than the Commission reported last year because of higher Medicare fee updates, reduction in the trend for private fee growth, and more accurate data on "deep discount" payers. The gap between Medicare and private fees is of concern because large differentials in payment between Medicare and private payers, coupled with discontent about Medicare's level of payment, could compromise access to care for Medicare beneficiaries. Even if the payments cover the cost of care, physicians may prefer to accept patients with private insurance over those with Medicare. The Commission has found no evidence that the current gap is causing an access barrier. It is possible, however, that a substantially larger gap could affect physicians' willingness to treat Medicare patients, but the size of that threshold is unclear.

Managed Care

As the health care system has moved toward managed care and integrated delivery systems, both the willingness of health maintenance organizations (HMOs) to participate in the Medicare program and beneficiary enrollment in these plans have increased. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs, up from 7 percent in 1993. Enrollment rates vary considerably across the country, with higher rates tending to occur where commercial HMO penetration is high. About 75 percent of enrollees are in HMOs with risk contracts which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on reasonable costs.

Further expansion of managed care within the Medicare program will depend upon the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Although short-term budget savings could be achieved by reducing capitation rates, this approach would risk making the program less attractive to plans and thus would be counter to long-term goals. My remarks will focus primarily on needed changes in the current payment methodology that could ultimately encourage a more substantial role for managed care within the Medicare program. These reforms also offer some opportunities for savings.

Inadequacies of the current Medicare payment policies have created problems of limited HMO participation, low beneficiary enrollment rates, and higher costs per enrollee than their fee-for-service costs would have been. These payment problems include:

- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- volatility of county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

Without addressing these problems, a greater role for managed care will not necessarily lead to cost savings.

In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as average adjusted per capita costs or AAPCCs). Building upon this foundation, additional managed care choices (such as Medicare Select and other preferred provider or point-of-service options) could be expanded. Other approaches that would create competition among both fee-for-service and managed care options within Medicare could also be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with multiple HMOs, both approaches are needed in the short-term. Also important is the need for payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Given the inadequacies of current risk adjustment methods, partial capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Each of these is discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from Medicare fee-for-service expenditures, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon the design of the bidding process, how competitive the bidding becomes, the final payment rates, and the level of the AAPCCs in those markets. Cost savings for Medicare might be achieved if the final payment rate is set close to the low bids or if competitive bidding results in rates lower than the AAPCCs. On the other hand, if bidding results in a rate higher than the AAPCC, a decision could be made to use the national average per capita cost as an upper limit. (This rate should be adjusted for local input prices and possibly for some variation in service use.) Such an approach is not an ideal one, however, because it would reintroduce the very problems that competitive pricing was intended to correct and distort competition by preventing the established price from reflecting local market conditions.

To enhance prospects for successful implementation, the Commission recommends that the Health Care Financing Administration (HCFA) be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in competitive markets, there will continue to be a need for the AAPCCs or some other form of administered payment rates in the forseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement. Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, these problems could be addressed by making appropriate payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates or supply costs, and service use variation attributable to differences in health status. Because we are now unable to adjust accurately for differences in service use, the Commission's recommended short-term strategy for improving the AAPCCs is to establish payment rates for multi-county areas instead of individual counties. Such rates for multi-county areas would improve payment predictability, particularly for rural areas, and would eliminate payment variation across counties within HMO markets. In the long-term, better adjustments for service use should be developed.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could be used (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare fees, and (2) risk corridor payments that would adjust capitation rates in proportion to its net financial gains or losses exceeding established thresholds.

Despite its promise, partial capitation could be difficult to adminster. Before using this method widely, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

The Role of Cost Contracts. Cost contracts have long been made available for HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk contracting HMOs with increased costs to Medicare. In markets where competitive pricing or partial capitation are implemented, limits should be placed on the use of cost contracts.

GRADUATE MEDICAL EDUCATION

Another factor affecting Medicare expenditures is the supply and distribution of physicians. The fact that per capita spending is positively correlated with the number of physicians has been well documented, and there is some evidence that care provided by specialists is more expensive than that provided by primary care physicians. Since the Commission's mandate was expanded in 1990 to include consideration of Medicare financing for graduate medical education and the supply and specialty distribution of physicians, we have developed substantial expertise on these issues.

Recognition of the need to address supply and specialty distribution and the substantial contribution of Medicare to supporting residency training prompted both the current and prior Administrations to revise the payment methods for GME. Under current law (established in the Consolidated Omnibus Budget Reconciliation Act of 1985), payments are made to hospitals based on institution-specific per resident costs from the 1984 or 1985 reporting years, updated for inflation. These costs are multiplied by the number of full-time equivalent (FTE) residents in the hospital during the payment period. A modification of the OBRA85 provisions calls for residents being weighted as one-half an FTE beyond the initial training period.

Previous proposals have suggested restructuring Medicare support by (1) introducing weighting so that residents in primary care disciplines are treated as more than one FTE and others in the initial training period are treated as less than one FTE and (2) basing payments on the national average salary for residents rather than hospital-specific historical payments. Such proposals can be designed to be budget-neutral or to achieve savings.

While the Commission has long supported moving to a national per resident amount, it questions whether weighting will actually increase the proportion of residents trained in primary care. This is because direct payments go to the hospital and not necessarily to the primary care training program. Moreover, the additional funding from weighting may not be sufficient to increase the supply of primary care physicians; training programs in these fields already have substantially fewer filled positions than those in many other specialties. To better inform the Congress about the implications of such proposals, the Commission is planning to model the impact of proposals to change GME financing. These analyses should provide a more complete picture of the financial impact of Medicare budget cuts by specialty and by type of hospital.

In addition, the Commission can provide additional advice on broader reforms in GME financing that would move specialty distribution and supply in a direction consistent with the need to reduce Medicare expenditures. These might include shifting funding to support training in ambulatory sites or other mechanisms that would break the linkage between hospital payment and GME financing and thus allow more creative and effective uses of Medicare dollars.

Chairman THOMAS. Thank you very much, Doctor, for your ideas and rather extensive options available to us.

Mr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Well, thank you, Mr. Chairman. It is really a pleasure to be here. I have really appreciated the opportunity over the years to testify before this committee, working with you as well as Mr. Stark and the staffs.

I have with me Dr. Donald Young, who is the Executive Director of the Prospective Payment Assessment Commission.

As you know, Mr. Chairman, ProPAC was originally established to help the Congress think through the complexities of the prospective payment system diagnosis related groups, which is the system which was put in place in 1983 to pay hospitals, but the Congress has expanded our mandate considerably over the years. We now focus on skilled nursing facilities, home health, hospitals which are excluded from PPS, as well as working on end-stage renal disease for dialysis.

In addition, the committee has asked us to look into several other plans for the Medicare program, as well. We have looked quite extensively at how Medicare has operated over the last several years; and, as Dr. Eisenberg has pointed out, we share his focus that while the price increases have been important, one needs to focus attention heavily on volume. And we, too, have been looking into different ways of focusing on volume.

But you asked us today to give you our best assessment of how you, in the short run, can control Medicare costs as well as plan for the future, so I will focus most of my testimony on changes in the Medicare program in the short run but look to the future, as well.

As we look to the short run, we should recognize Medicare is a fee-for-service system. In the hospital payment, we created in 1983 a minicapitation system for inpatient hospital care. Prior to that, Medicare paid on the basis of cost. The more a hospital spent, the more it got paid.

Now Medicare says to a hospital, here is a fixed amount of money. You manage that amount. If you provide more tests and procedures, you have to do it within that fixed budget. But it doesn't control services outside the hospital in the same way.

So much of the growth over the last 3 years has not been in the prices paid to hospitals. It has been in the growth of home care services, in the growth of skilled nursing facilities, as well as some increase in the number of admissions.

Now, in thinking about how we might be able to control the hospital side first, we really have two basic paths to go down:

One, we could reduce the update factor, which is the method we use to increase hospital payments by a fixed amount for every hospital. And there is a certain appeal to that. It is simple. It has a sense of fairness.

The problem with it is that some facilities are in a much better position to take those reductions than others, and it may turn out that the ones you want to preserve are just the ones that are going to be in trouble if you introduce across-the-board reductions. So the alternative would be to focus reductions on institutions that may not need the money as much or where there is a questionable amount of money that has been flowing to them.

Let me indicate some of the areas where we might go. And, by the way, I have appended to my testimony a number of charts which you may want to refer to as I just quickly move through this testimony.

The first chart indicates the fact that Medicare was a fairly prudent controller of expenditures from 1983 to 1991. But, beginning in 1991, the growth rate of 6.5 percent on average per year was significantly more than the private sector, which was 4.7 percent.

Chart 2 demonstrates what I was talking about, that while overall Medicare expenditures grew by 11.8 percent between 1991 and 1993, it grew by 38 percent for home health. It grew by 46 percent for nursing homes, while hospitals grew at about 10 percent.

Now, let's focus more specifically on the hospitals, particularly the hospitals that receive most of the money. Even though the inpatient sector is declining, it is still where most of your money goes in the Medicare program. Of the total $151 billion that Medicare spent in 1993, about $80 billion went for inpatient hospital care or about 52 percent of the total.

Now, when you look at the growth rates, they have been fairly moderate in recent years. The update factors have been held down, but the current law which allowed the Medicare program to essentially pay 2 percent less than the market basket is going to phase that reduction down to and, by 1998, that would essentially go to zero.

One real possibility that you have is not to allow that reduction to take place and to keep the 2 percent below market basket in place. I say that, and I feel more confident in saying that because the hospital cost structure, which resisted reductions even though Medicare was paying out less because of the ability to charge private patients more than their costs, is now beginning to fall and is being pushed by private-sector reductions in prices that they pay to the hospitals.

I think the Medicare program should essentially ride that curve down, not be excessive about it, because you don't want Medicare to get out of balance any more than it already is with what private payments are. But neither do you want Medicare to become the best payer in town, except when you design it specifically for a specific hospital.

So one possibility would be to focus on that update factor and to tie it more closely to where it had been during the middle eighties.

Now, we can focus on a number of special issues. One of the most complex and controversial is the teaching adjustment. The Congress, in establishing the PPS, decided, based on analysis, that it was important to pay teaching hospitals more than just their flat DRG payment because teaching hospitals get sicker patients. They also are training our next generation of physicians, and these younger physicians use more tests and procedures and they also treat larger numbers of uninsured people.

And so the Congress built into the legislation an increased payment. Unfortunately, they overshot the mark a bit. Well, that is being kind. They overshot the mark a fair amount and wound up paying hospitals about 11.2 percent for every 10-percent higher ratio of the interns and residents to beds. Over the last several years, that teaching adjustment has been reduced somewhat to about 7.7 percent.

We at ProPAC have been looking at this. Our best estimate is that that teaching adjustment should be around 4.5 percent, not 7.7. But we believe it would be a mistake to simply reduce that amount from 7.7 to 4.5 in one shot.

You have to appreciate the problems of teaching hospitals. They are, after all, often located in our urban centers, treating many of the uninsured. They do have higher costs because of the factors that I indicated, and they are the group that are the most negatively affected by this pressure for managed care in the private sector.

That doesn't mean that we support just continuing to pay them higher rates. Our recommendation would be this year to reduce the 7.7 percent to 6.7, which is about a 13-percent payment reduction, followed in the second and third year by comparable reductions. Over time, that would reduce teaching payments by about 40 percent, which is a significant reduction.

We also have looked at the graduate medical education component that Dr. Eisenberg talked about, and we have similar thoughts about that in terms of either freezing the payment rate, the number of residents, or reducing the payment rate per resident to something above the national average or in some way focusing the payments much more on primary care and away from specialty care.

Now, as we look at other areas, we need to recognize that one of the other adjustments that the Congress put in the DRG system was to focus extra dollars to what we call disproportionate share hospitals. These are hospitals mostly in our urban areas, some in rural but mostly in our urban areas, that treat large numbers of people, Medicare people and Medicaid and uninsured people that can't pay their bills.

These are very financially vulnerable hospitals. So the Medicare program provided an extra subsidy. In 1989, this subsidy was $1.1 billion. By 1994, this subsidy had grown to $3.4 billion, representing over 5 percent of the prospective payment system.

Our estimate of what the disproportionate payment would be in 1995 is $3.7 billion.

In general, ProPAC has supported the disproportionate share adjustment. It has provided a very meaningful averaging and allowed institutions to survive. However, like any blunt tool, it has allowed some institutions to get this payment without providing quite the level of uninsured or uncompensated care as others.

We believe a much more focused disproportionate share payment could be devised, and we are working on that and would be glad to work with you and your staffs to see to the extent to which we can focus those dollars more specifically at the hospitals that bear the largest burden.

The third group of hospitals that have benefited from very specific legislation by the Congress and the administration has been rural sole community hospitals. The DRG system unintentionally in the beginning did serious financial harm to rural hospitals, but over the last 10 years the Congress and the Commission has rectified that to the point that, in many communities, Medicare is the best payer for rural hospitals.

But here, too, we believe those dollars can be better focused; and we need to work with States and rural areas to make sure that we are keeping going only those hospitals that should be kept going.

Nevertheless, we at ProPAC support the continued rural adjustment, particularly for sole community hospitals—these institutions which, if they were to stop, would cause serious harm to the limited number of people that live in those areas.

One of the complicated aspects of the prospective payment system is the fact that capital which, after all, is about 10 percent of payments has now been restructured in a way that fits within the DRG system we at ProPAC support. That we believe that was a good adjustment. However, there was a mistake made in the early stages, not intentionally, but based on limited information; and there is an overpayment in the capital structure that we believe should be over time reduced; and there is substantial dollars that could be saved by focusing on reducing that payment.

There are hospitals which are excluded from PPS, children's hospitals, certain hospitals that do rehabilitation and others. These, too, can benefit—have benefited from increases in the update factor. It is not as complicated a system; and there is not as much to squeeze out here; but here, too, dollars can be better targeted.

When we shift from the inpatient to the outpatient, you are dealing with a major increase in spending. And, as I referred to back in chart 2, hospital outpatient has been growing by almost 14.3 percent per year between 1991 and 1993. Again, much of the increase is the result of volume which cannot be dealt with by just changing the payment structure. Medicare is not a high payer for outpatient services, but it is a fee-for-service outpatient system; and, therefore, some of the potential savings that the private sector has generated through managed care is lost. So here, too, we would recommend thinking seriously about developing some partial capitated or fully capitated system to benefit from reducing outpatient services.

It is only reasonable that as the hospital length of stay has fallen off, more people should use skilled nursing facilities. They are less expensive, and they target services better. However, we are getting very concerned about the growth in ancillary services that are being provided to these patients once they are in the facilities. Much of the annual spending growth of 46 percent is the result of ancillary services being given and charged on a fee-for-service basis in addition to the base payments.

We at ProPAC are completing our study, and we hope to have it done within the next several months to give you some recommendations on how you might deal with this. Again, some growth in skilled nursing facility payments was very appropriate. But the 46 percent leaves us with significant concern.

And that brings me to the second major growth area, which is home care. Again, home care tied into a balanced delivery system makes a lot of sense. True, as we have cut back length of stay and admissions, growth in home care should have increased. But we are getting concerned, as are most others here in Washington and around the country, about growth rates which are 30, 40 and 50 percent per year. Much of the growth is in the number of visits per beneficiary, not in the price.

Medicare has a tough home payment system. You could get some reductions by limiting that payment rate, but you need to focus on controlling volume.

In another life of mine at Brandeis, we have conducted over a long period of time a demonstration which was called the Social Health Maintenance Organization System where we gave a limited number of HMOs 100 percent of the AAPCC and told them they needed to provide home care and some long-term care, as well. What that experiment clearly indicated to me was that in a managed care environment home care can be delivered much more efficiently without the growth that you have seen in the fee-for-service.

In my testimony, I have laid out other home health options. An introduction of coinsurance is possible, putting back the 100-day limit which used to exist or even putting back the prior hospitalization.

I personally don't favor putting back the prior hospitalization. I think a much better managed care environment is the way to go.

Now, finally, we, too, have looked hard at the issue of Medicare managed care. There is no question that 5 percent of the Medicare population in managed care is too low. It is growing, and what is interesting is that the people that go into managed care among seniors are as satisfied or more satisfied with their care as individuals who are under 65. That doesn't mean that managed care is for everybody, particularly for many very sick seniors, but there is much greater growth that is potentially available.

To do that, however, requires substantial changes in the law. And I would emphasize we need to change the law. We need to change the way Medicare pays for managed care, not only because it would expand the number of managed care plans coming in, which it would, but also, if we are not careful, Medicare could actually lose money by putting more people into managed care because the current system allows a Medicare beneficiary to go into managed care and then, when they get sick, to drop out of managed care and go back into the fee-for-service system. Well, that may be good for the beneficiary but just think about the program.

The program is paying an average payment which includes not sick people and sick people, and then if the sick people go back into the fee-for-service system, it offers the real potential for the managed care plans to do quite well but for the Medicare program to wind up paying too much money.

The current Medicare program pays an average amount. It has a few categories, but we are just not capable of coming up with what are called risk, really risk-adjusted premiums. So if you are not careful you could wind up with the younger, less sick people in managed care and the older, more sick people in fee-for-service; and we have sort of blown the 5-percent savings.

Again, this need not be the result of the managed care plans doing anything. It is not that they have done anything wrong. They are just sitting there taking people who are coming in, and the people who are likely to come in are likely to be less sick and younger.

Now, if they had stayed in over their whole lifetime, they would get sick, and then the managed care plans would deal with them. But if they bought back out into the fee-for-service, Medicare could lose money. So we need to look hard at this, but that is clearly an area for future growth. And we at ProPAC are working hard to try to help you think about that.

Again, Medicare embarked on an interesting change in its payment system in 1983. For the most part, it has worked pretty well, not perfect, for inpatient hospital care, but it has not been broad enough, and it has not encompassed the kind of managed care aspects that the private sector has, and there are clearly things that we could learn from them.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, PH.D.
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to testify today as you begin to consider alternative ways to control the rapid rise in Medicare spending. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Because many new members have joined the Subcommittee since I last appeared before you, I would like to briefly describe the mandate and work of the Commission. ProPAC is an independent Congressional agency that was established in the 1983 legislation that created the Medicare prospective payment system (PPS) for inpatient hospital services. Originally, the Commission's primary responsibility was to examine issues related to PPS and provide advice for updating and improving it. Over time, Congress has expanded our mandate to include providing analyses and making recommendations concerning Medicare policies for facilities excluded from PPS and hospital outpatient, skilled nursing facility, home health, and end-stage renal disease dialysis services. In addition to an annual report containing ProPAC's recommendations, we also are required by statute to submit each year a report to Congress describing the relationships between Medicare and the American health care system. Periodically, the Congress also requests other reports concerning Medicare, Medicaid, and the changing health care system.

MEDICARE SPENDING GROWTH

Between 1992 and 1993, Mr. Chairman, Medicare spending for services furnished to its beneficiaries increased about 11 percent, to $151 billion. The Medicare population is growing faster than the general population and about 20 percent of this spending growth can be accounted for by more beneficiaries and their increased age. Inflation in the general economy, as well as additional growth in the price of medical goods and services providers purchase, also contributes to the escalation in Medicare spending. But there is one other responsible factor that I will return to frequently during my testimony: much of the recent acceleration in expenditures is due to more Medicare beneficiaries receiving more and more services each year.

As members of this Subcommittee are aware, Medicare continues to be predominantly a fee-for-service payment system. This payment method provides strong incentives for physicians and other providers to furnish more services to beneficiaries who are willing to receive them. Many of these services, however, may be of limited medical value to specific individuals. The private insurance market is responding to this problem by developing alternative payment systems based on capitation and managed care. These methods contain strong financial incentives for providers themselves to control the cost of each unit of service furnished as well as the number of service units. There also are incentives to furnish high quality care to the extent purchasers and their enrollees also consider this factor in selecting among competing plans and providers.

While more and more Medicare beneficiaries are choosing capitated, managed care plans, overall enrollment lags well behind that of the private sector. There are a number of reasons for this, several of which I will discuss in a moment. To explain all the issues involved with Medicare managed care, however, would require me to go into considerable detail and to suggest a number of changes to the Medicare law. We at ProPAC have been working on these issues, and I would welcome the opportunity to give you our thoughts at the appropriate time. You requested, however, that today I focus on changes to the existing Medicare program that might control spending growth in the short term. This I will do, but I want to emphasize that much of this growth is due to Medicare policies that encourage increases in the volume of services provided and more fundamental changes in the law are necessary to correct these incentives.

Over the past decade, the Medicare program generally has done a good job in implementing policies that controlled increases in payments for individual services. The first major change was the shift from cost-based reimbursement for inpatient hospital services to the Medicare prospective payment system (PPS). While some considered this an administrative pricing system, it also could be considered a minicapitated payment plan for inpatient services during each patient admission. The effects of the PPS system and other Medicare policy changes over the past decade can be seen in Chart 1. Between 1979 and 1983, real Medicare spending per enrollee--that is, adjusted for inflation--was growing faster than private health insurance expenditures per person. Medicare policies enacted in the early 1980s reversed this trend, with Medicare spending between 1983 and 1991 rising much more slowly than the private sector. Between 1991 and 1993, however, Medicare spending growth accelerated, exceeding private sector increases.

Spending increases in settings outside the hospital are partly responsible for the renewed rise in Medicare expenditures (see Chart 2). While the bulk of Medicare spending continues to be for inpatient hospital services, home health and skilled nursing facility expenditures are growing rapidly. Between 1991 and 1993, hospital inpatient spending increases averaged 10 percent annually, while payments for home health and nursing facility services grew at rates of 38 percent and 46 percent per year, respectively. As I will discuss in a moment, increases in the number of these services furnished to beneficiaries is a major contributor to this spending growth.

MEDICARE PAYMENT POLICIES

Mr. Chairman, given this brief background, I now would like to turn to a discussion of possible changes in Medicare payment policies in the short term that could alter overall spending growth. There are two broad ways of approaching these changes. The first is to apply an across-the-board reduction in the level of the update factors that determine how fast payments for each unit of service rise. The Medicare program periodically applies an update factor to the base payment amount for hospitals, skilled nursing facilities, home health agencies, and other providers. A similar reduction in update factors for all facilities could be seen as being fair, in that all providers will contribute to the slowing of Medicare spending growth. This approach, however, may fail to recognize the special needs of certain types of providers that Medicare patients rely on. Accordingly, a second approach could target slowdowns in payment growth to specific groups of facilities through differential payment updates or through refinement of other payment policies that target these facilities.

I now would like to turn to several specific suggestions on possible changes in Medicare payment policies.

PPS HOSPITALS

Medicare payments for individual PPS hospitals reflect both capital and operating expenses. For operating expenses, hospitals receive a payment based on the hospital's location and the assigned diagnosis-related group (DRG) plus additional payments if the hospital qualifies. These include special payments to teaching hospitals and hospitals that serve large numbers of low income individuals. PPS hospitals also receive additional payments for their capital costs and, for teaching hospitals, the direct costs of graduate medical education programs. PPS spending can be constrained by controlling increases in the base payment rate, the individual payment adjustments, capital payments, or a combination of approaches. The route that you choose to slow spending growth will impact hospitals differentially, depending on their current level of overall Medicare payments and the degree to which they rely on the additional payments. Many of the options that I am going to discuss would affect the same groups of hospitals, and therefore the impact on access to care for Medicare beneficiaries of the total package of spending changes also must be carefully assessed.

Limiting the Increase in the PPS Update Factor

Since the third year of PPS, the increase in the annual update factor has been less than the rise in the market basket index that measures the rate of inflation in the prices of goods and services hospitals purchase. Inpatient hospital payments per case, however, have grown somewhat faster than the market basket as hospitals submitted bills for more complex and costly patients (see Chart 3). Until recently, however, hospital costs have grown even faster than payments. As a result, hospital PPS margins (or profits) have been negative since 1990 (see Chart 4).

The overall financial effect of Medicare's update policies is related to hospitals' ability to reduce cost growth or to obtain additional revenue. Until recently, instead of reducing costs as Medicare (and Medicaid) constrained payments, hospitals responded by increasing revenues from private payers. Consequently, in 1992 hospitals spent $26 billion more than they received from public payers for the costs of furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they received $29 billion more from private payers than their costs of providing care to privately insured patients.

More recently, increasing price competition in the health care market place is affecting the ability of many hospitals to obtain excess revenues from private payers to subsidize losses from government programs. Many hospitals are responding to these market pressures by reducing costs. Hospital cost growth began to fall dramatically in late 1992, and the decline is continuing (see Chart 5). Prior to 1993, real hospital costs per case--that is, adjusted for inflation--were growing about 4.7 percent annually. In 1993, this rate dropped to 1.7 percent. This downward trend continued in the first nine months of 1994, with the change in real costs actually becoming negative.

This dramatic decline in cost growth must be considered as Medicare determines its update policies. Current law sets the PPS update factor at 2 percentage points less than the market basket for fiscal year 1996. The update factor is scheduled to increase by the market basket minus 0.5 percentage points in 1997 and by the full market basket in 1998. If the current cost slowdown continues, the updates scheduled under current law would be higher than anticipated cost increases.

Consequently, you may wish to continue with an annual update factor at 2 percentage points less than the market basket beyond 1996. You could then examine this factor each year and adjust it further if hospital cost reductions continue.

Currently, the financial condition of the average hospital continues to be good, although many individual hospitals are experiencing financial distress. A number of these hospitals treat large numbers of Medicare beneficiaries, as well as Medicaid and uninsured patients. These facilities have a limited ability to obtain surplus revenues from private payers to cover losses from the care of their other patients. The effects on Medicare beneficiaries served by these hospitals, therefore, must be considered as we examine alternative ways to slow spending growth.

Reducing Differences in Base Payment Amounts

The payment each PPS hospital receives for each case is determined by the hospital's standardized payment amount (SPA) and the relative weight of the assigned DRG (diagnosis-related group), together with certain adjustments and additional payments. When PPS was implemented, there were two standardized payment amounts, one for rural areas and one for urban areas. Subsequently, Congress split the urban hospitals, creating one SPA for hospitals located in metropolitan statistical areas (MSAs) with populations of 1 million or more (called large urban areas), and another SPA for all other urban hospitals. In fiscal year 1995, the difference between the large urban and the other urban SPAs is about 1.6 percent.

In OBRA 1990, Congress mandated a phase-out of the differential in the SPA between rural and other urban hospitals. This phase-out was completed in 1995. Consequently, there are now only two SPAs, one for large urban areas and one for all other areas. Congress could consider phasing-out the differential between the large urban and the other standardized amounts. This differential was put in place in the early years of PPS, to recognize the slightly higher costs of hospitals located in large urban areas. Since that time, many of these hospitals have benefitted from increases in the disproportionate share adjustment and from the teaching adjustment. Payments to these hospitals account for 53 percent of all PPS payments (see Chart 6). They also receive 74 percent of IME payments and 61 percent of DSH payments. In 1992, their PPS margins were a full percentage point better than that for all hospitals combined (see Chart 7). It also should be recognized, however, that because of the patient populations many of these large urban hospitals treat, their total margins were less than average.

Reducing Growth in Payments for Medical Education

The Medicare program provides extra payments to hospitals with graduate medical education programs. There are two types of these payments. First, teaching hospitals receive an adjustment to their PPS payments to reflect the added patient care costs associated with operating a teaching program. This indirect medical education (IME) adjustment will account for about 5.3 percent of total PPS operating payments in fiscal year 1995, or about $3.7 billion. Medicare also pays teaching hospitals an additional amount, separate from the PPS payments, for the direct costs of maintaining graduate medical education programs. These payments (referred to as GME payments) cover resident salaries and benefits, the salaries of supervising physicians, office space, and other overhead. These payments are expected to total $1.4 billion in 1995. I will first discuss the IME adjustment and then return to GME payments.

The amount of the IME adjustment depends on a hospital's teaching intensity, measured by the number of interns and residents per bed. Currently, payments increase about 7.7 percent for each 10 percent increase in teaching intensity. Each year, ProPAC estimates the relationship between teaching intensity and standardized Medicare operating costs per discharge. The most recent analysis indicates that, on average, a 10 percent increase in teaching intensity is associated with a 4.5 percent increase in Medicare operating costs per discharge.

As we have reported to you previously, since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. In 1992 major teaching hospitals, those with 25 or more interns and residents per 100 beds, had the highest PPS margins of any group of hospitals. Their total margins, however, were among the lowest of any group, related in part to the large amount of uncompensated care many of these hospitals furnish. The PPS and total margins for other teaching hospitals were similar to the average for all hospitals.

This year, as we have for several years, we are recommending a reduction in the IME adjustment. We recommend lowering the adjustment in 1996 from 7.7 percent to 6.7 percent for each 10 percent rise in the number of interns and residents per bed. This is equivalent to a 13 percent reduction in the amount of IME payments. This reduction is the first phase of a three year plan which will bring the teaching adjustment in line with the amount our analyses suggest is appropriate. We have chosen this phasing approach to allow teaching hospitals time to adjust to the large reduction in payments this would represent. The Commission also is concerned that accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. While we are not suggesting that all of these costs should continue or that all of the current payments are necessary, we believe that this country should also consider an alternative financing system for graduate medical education.

As I indicated, Mr. Chairman, Medicare also pays teaching hospitals a share of the direct costs of maintaining graduate medical education programs. These GME payments are based on a hospital's per resident costs in a base year, updated to the current year. Hospital-specific per resident costs in 1990 ranged from less than $10,000 to more than $100,000. Consequently, Medicare per resident payments also vary widely across teaching hospitals. Payments also differ if the resident is in an initial residency or in a second residency, or in a primary care or specialty program. GME payments have increased in recent years, as the number of residents has grown.

There are a number of ways Congress could slow the growth in spending for GME. For example, it is not clear that the value to Medicare of the increasing number of residents is worth the cost. One approach would be to set a cap on total GME payments related to the number of residents in a base year. If the number of residents increases, then payments per resident would be reduced to keep the pool constant.

As I noted, there are large variations in per resident payments across teaching programs. Another option, therefore, is to set an upper limit on the amount of the payment per resident. The annual update in per resident payments could also be reduced for specialty residents or for all residencies. In addition, Medicare could restrict payment to only one period of residency training or to a certain number of years of training.

Targeting Payments to Disproportionate Share Hospitals

Hospitals that treat a disproportionate share of low income patients also receive an adjustment to their PPS payments. Many of these hospitals experience difficulties recruiting physicians and other staff, meeting the special needs of their patients, and obtaining sufficient revenue to cover the costs of caring for large numbers of individuals without insurance. The DSH adjustment is intended primarily to help assure access to care for Medicare beneficiaries who rely on these hospitals. In contrast to the IME adjustment, the DSH adjustment is not closely tied to additional Medicare operating costs per discharge, except for large urban hospitals.

In the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990, Congress substantially increased the amount of DSH payments. In 1989, these payments were $1.1 billion, representing 2.4 percent of PPS operating payments. In 1994, they are expected to be $3.4 billion and to account for 5.1 percent of PPS payments (see Chart 8). In 1995, DSH payments will rise to an estimated $3.7 billion.

Some hospitals, however, benefit from these extra payments without bearing the same burden in terms of financial losses as other hospitals. For example, disproportionate share hospitals in large urban areas have the lowest average total margin and the highest share of negative margins of any group of hospitals. In contrast, disproportionate share hospitals in other urban and rural areas have much higher than average total margins.

One approach the Congress can consider is scaling back the substantial expansions in DSH payments that were enacted in 1989 and 1990 and better targeting the available funds to those hospitals with the largest share of low income patients that are essential to maintain access for Medicare beneficiaries.

Targeting Payments to Sole Community Hospitals

Sole community hospitals (SCHs) are considered to be the main source of care for a geographically isolated population. SCHs are paid the higher of the applicable PPS payment or their hospital-specific costs in 1982 or 1987, updated to the current year. About 60 percent of SCHs currently receive payment based on their hospital-specific base year costs. In addition, other Medicare policies allow many of these hospitals to qualify for DSH payments under policies applicable to urban hospitals.

About 600 hospitals are designated as SCHs. The PPS margins for these hospitals have increased substantially as a result of recent changes in Medicare policies. The overall financial condition of these hospitals also is better than the average hospital (see Chart 7).

Many of the hospitals that receive special treatment under the SCH provisions are not truly isolated, because they were "grandfathered" when the current designation criteria were implemented. The Congress may wish to limit the special treatment for SCHs to those that are truly isolated and serve as the only available hospital for Medicare beneficiaries residing in remote areas.

Correcting for Capital Cost Overestimates

The costs hospitals incur to acquire capital were excluded from PPS when it was implemented beginning in late 1983, with payments continuing on a reasonable cost basis. In fiscal year 1992, hospitals began a 10 year transition to a fully prospective payment system for capital. During the transition, each hospital's capital payment is based on one of two methods. The determination of the method as well as the amount of payment to each hospital is based in part on a comparison of each facility's "hospital-specific rate" (updated base year capital costs) and the adjusted "Federal rate" (a national average capital cost per discharge).

The base year capital costs were estimated using the best data available at the time. Similar data was also used to project the expected growth in capital costs from the base year to 1992, the first year of the capital transition. In fact, we now know that actual hospital capital costs were less in the base year than was estimated. In addition, the updates applied to inflate the rates to 1992 also were too high. Consequently, both the hospital-specific rate and the Federal rate are higher than they would have been if actual data had been available. In OBRA 1993, Congress partially corrected for the overestimates by reducing the Federal rate. Both the hospital-specific rate and the Federal rate, however, continue to be higher than intended. Congress may wish to reduce the level of both rates to bring them in line with actual base year costs and actual capital cost growth prior to the beginning of the transition.

EXCLUDED HOSPITALS

Certain specialty hospitals and distinct-part units of general hospitals are excluded from PPS, if they meet certain requirements. These facilities include psychiatric and rehabilitation hospitals and distinct-part units, as well as children's, long-term care, and cancer specialty hospitals.

Each excluded provider is paid on the basis of its current Medicare allowable inpatient operating costs or a target amount. The target amount is based on the provider's costs per discharge in a base year, updated to the current year by an annual update factor. This payment mechanism rewards providers that keep their costs below the target amount and penalizes those that exceed the amount.

From 1989 to 1993, a market basket measure of price increases was used to update the target amount for these facilities. In OBRA 1993, Congress reduced the update factor by up to one percent for certain facilities for fiscal years 1994 through 1997.

These facilities account for a small share of total Medicare spending, although this share has been growing rapidly as more beneficiaries use these services. Congress could slow spending growth modestly by further reducing the annual update factor. They could also apply the reduced update to all facilities.

HOSPITAL OUTPATIENT SERVICES

Mr. Chairman, I would like to turn now to Medicare reimbursement for hospital outpatient services. Because of its rapid growth--14 percent in 1993--hospital outpatient spending is an increasing share of total Medicare expenditures. For the past several years, the Commission has recommended a correction to the formula that determines hospital outpatient payments for ambulatory surgery, radiology, and other diagnostic services that would generate significant savings.

Currently, hospitals are reimbursed for these services based on a formula that incorporates the hospital's costs and charges, and a prospective rate. Medicare program payments are then reduced to reflect beneficiary coinsurance. The problem, Mr. Chairman, is that the beneficiary coinsurance is not based on Medicare's payment but on each hospital's charges. Hospital charges are about two times higher than Medicare payments, according to HCFA estimates. Thus, the beneficiary coinsurance is significantly more than the traditional 20 percent of payments. Because the Medicare payment formula does not fully offset these higher beneficiary copayments, hospitals end up receiving more than Congress intended.

While correcting this formula-driven overpayment could generate significant savings, ProPAC has recognized that beneficiary payments representing 50 percent or more of total payments also is not what Congress intended. The Commission believes that these amounts could be reduced by linking the coinsurance payment to an estimate of payments, rather than charges. We are aware that correcting this flaw would increase Medicare outlays and, therefore, have recommended that the savings achieved by correcting the payment formula should be used to reduce the excessively high beneficiary copayments.

SKILLED NURSING FACILITY SERVICES

Mr. Chairman, I next would like to turn to Medicare's post-acute benefits--skilled nursing care and home health services. The Medicare skilled nursing facility (SNF) benefit is intended to be an extension of a hospital stay, at a lower level of care. As I mentioned previously, Medicare spending for SNF services is escalating rapidly. This growth is related to the rising number of beneficiaries using SNF services and increases in the number of days per person served (see Chart 9). These increases are due in part to decreasing lengths of stay in the inpatient hospital setting. Spending growth has also increased recently due to substantial increases in average daily SNF reimbursement (see Chart 10). ProPAC is examining this recent growth. We believe it may be related to a surge in the number of ancillary services being furnished and billed for separately from the routine per diem payment.

SNFs are paid their costs for routine per diem operating expenses, subject to a limit. A separate payment is made to cover capital costs. In addition to these payments, skilled nursing facilities receive reasonable costs (without limits) for the ancillary services provided to patients receiving SNF-level care. They also may bill under Part B of Medicare for ancillary services furnished to inpatients who have exhausted Part A benefits or to outpatients.

Currently, free-standing skilled nursing facilities are paid the lower of their costs or 112 percent of the average per diem costs for urban or rural providers during a base year period. Hospital-based facilities receive a higher limit that is based on a combination of the free-standing limit and 112 percent of the average costs for all hospital-based facilities. These limits are periodically updated.

OBRA 1993 froze the SNF cost limits for fiscal years 1994 and 1995. Congress could continue to freeze or limit the increase in per diem cost limits for these facilities. An alternative is to reduce the cost limit level from the current 112 percent to a lower amount. Another option to slow spending growth would be to reduce or eliminate the differential between hospital-based and free-standing limits. I need to note again, Mr. Chairman, that while these changes would slow the growth in per diem payments, they would have little impact on the increase in utilization that is primarily responsible for driving up spending. We will provide you with the findings from our examination of the increasing ancillary usage as soon as possible.

HOME HEALTH CARE

Home health services are the fastest growing spending category in the Medicare program. As I mentioned earlier, increases in the number of beneficiaries who use this benefit and the number of services they receive are responsible for almost all of this growth (see Chart 11). The number of beneficiaries using this benefit has doubled over the past 10 years. In addition, the average number of services used by each of these individuals has increased by almost one-fourth in just the last two years.

To qualify for the home health benefit, beneficiaries must be confined to the home, be under the care of a physician who prescribes home care, and require either intermittent skilled nursing or physical therapy services. Prior to OBRA 1980, Medicare required beneficiaries to have been in the hospital for a minimum of three days prior to receiving the home health service. Medicare also limited the number of visits to 100 per year. Since then, there has not been a hospitalization requirement or a limit on the number of visits a beneficiary may receive.

Medicare reimburses home health agencies their costs for the services they provide, subject to a limit. Each of the six types of services has a separate limit that is based on 112 percent of the mean cost per visit for all providers. An aggregate limit is then set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by that agency. Separate limits are set for rural and urban providers. The cost limits are updated annually using the home health market basket and adjusting labor costs by the current hospital wage index. As you can see, Mr. Chairman, this reimbursement scheme encourages these facilities to increase the number of visits they provide.

Over the past several years, Congress has attempted to rein in spending for home health care. The cost limits have been reduced from 120 percent to 112 percent of the mean cost per visit, the annual increases in the limits were frozen for fiscal years 1994 and 1995, and the administrative and general add-ons for hospital-based providers were eliminated.

While the Congress could reduce the cost limits per visit from 112 percent of the mean to a lower limit or continue to freeze or restrain the annual update, these actions will not address the fundamental factor driving spending growth, which is the increased utilization of services.

Similar to the Medicare SNF benefit, home health care was intended originally to be a post-acute benefit. Congress could change the current nature of the benefit and return to the policies that were in place prior to the 1980 law. That is, it could place a limit on the number of visits that a beneficiary could receive. Alternatively, a more formal managed care system could be developed to accomplish this goal. In 1992, 6.3 percent of all Medicare beneficiaries used home health services. The average number of visits per person was 54, although half of the beneficiaries used less than 25. On the other hand, almost 18 percent of the users had more than 100 visits and 10.8 percent of the users had over 150 visits (see Chart 12).

Congress also could return to the prior hospitalization requirement for beneficiaries to be eligible to receive home health services. Because the use of this benefit is growing so rapidly, it is difficult to get good data on the number of beneficiaries that have a hospitalization prior to using home health services. An analysis by ProPAC using 1990 data indicated that about 40 percent of users did not have a hospital stay within 30 days. A more recent analysis by HCFA indicated this proportion had increased to about 70 percent.

A final option that has been previously considered is to institute a copayment. Unlike hospital, nursing facility, or physician services, the beneficiary does not have any responsibility to share in the rapidly growing costs of this benefit. If Congress were to consider this option, there would be other questions to address. These include determining the amount of the copayment and whether it would apply from the first visit or after a certain number of visits.

The average reimbursement per home health visit in 1994 is estimated to be about $63. A copayment of 10 percent from the first day for 100 visits would total $630. This amount is less than the deductible for an inpatient hospital stay in 1994. If Congress decides not to require a prior hospital stay, an alternative would be to require a copayment only for users who did not have a prior stay.

MEDICARE MANAGED CARE

As I have described, much of the growth in Medicare spending is due to increases in service use inherent in Medicare's fee-for-service policies. While some of the growth can be slowed by tightening up on current policies, other approaches are necessary in the long term. Increasingly, private sector payers are turning to managed care as a way of controlling their rising health care expenditures. Managed care plans rely on a limited number of providers and capitated payment rates to manage both the price and volume of services.

Medicare offers beneficiaries the option of enrolling in a risk-based managed care plan that is similar to private sector managed care. Overall enrollment in these plans has risen slightly since the late 1980s, from 3 percent of the Medicare population in 1988 to almost 5 percent in 1994 (see Chart 13). While these figures lag behind the 19 percent enrollment rate in the general population, in several states, such as California and Arizona, almost 25 percent of Medicare beneficiaries are enrolled in risk plans. At the other end of the spectrum, states such as Alabama and Mississippi have virtually no Medicare managed care.

The Medicare risk program has the potential to reduce Medicare spending. Under its risk program, Medicare pays plans 95 percent of fee-for-service payments in a local area. In addition, volume is controlled because Medicare pays a fixed amount for each enrollee, regardless of the number or type of services delivered.

Under current law, however, Medicare may be paying too much for its managed care program. Studies of the risk contracting program to date indicate that Medicare savings have not been realized. The reasons are complicated, but relate to the methodology used by Medicare to pay managed care plans (including the absence of an adequate way to measure risk and set appropriate levels for the capitated rates) and the ability of plans to enroll healthier individuals. In addition, the requirement that all Medicare beneficiaries be allowed to disenroll from a plan with 30 days notice opens the possibility that enrollees will stay in a plan until they get really sick and then switch to the fee-for-service system to obtain maximum flexibility to choose their providers. This legal mandate also impairs the continuity of care offered by a plan. ProPAC is currently analyzing a number of these issues, including the Medicare payment formula and its relationship to private sector payment levels.

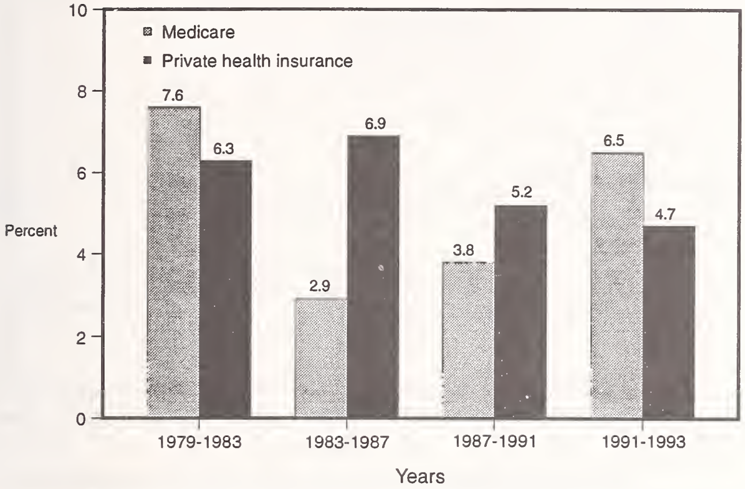
Managed care represents a fundamental change in the way Medicare services are delivered and paid. Currently, beneficiaries have a large choice of providers who are paid on a fee-for-service basis. While managed care controls volume-related spending increases, it also limits beneficiary choice as to the number of participating providers. Increasingly, however, beneficiaries are choosing this option and the satisfaction rate among those who choose managed care is very high. Other policy changes are needed to enhance the attractiveness of this program. The Commission believes that enhancing the opportunity for Medicare beneficiaries to select managed care and improving its payment methods has the potential to slow Medicare spending growth and to improve the quality of care for beneficiaries.

CONCLUSIONS

Mr. Chairman, today I have suggested a number of areas that the Congress could consider for reducing Medicare spending growth in the short term. These approaches parallel past practices of modifying the payment level for specific services furnished by specific providers. I must caution, however, that the Medicare program may be nearing the limits of its ability to slow spending increases using these methods. Over time new strategies are necessary to control increases in the volume of services that are characteristic of fee-for-service payment systems. Managed care may be one option. The challenge is to make short-term adjustments that will set the stage for these long-term goals and strategies.

The Commission would be pleased to work with you and your staff as you struggle with both short and long-term options for controlling the growth in Medicare spending. This completes my testimony, Mr. Chairman. I would be pleased to answer any questions you and the members of the Subcommittee have.

Chart 1. Real Change in Medicare Expenditures Per Enrollee and Private Health Insurance Per Member, 1979-1993 (In Percent)



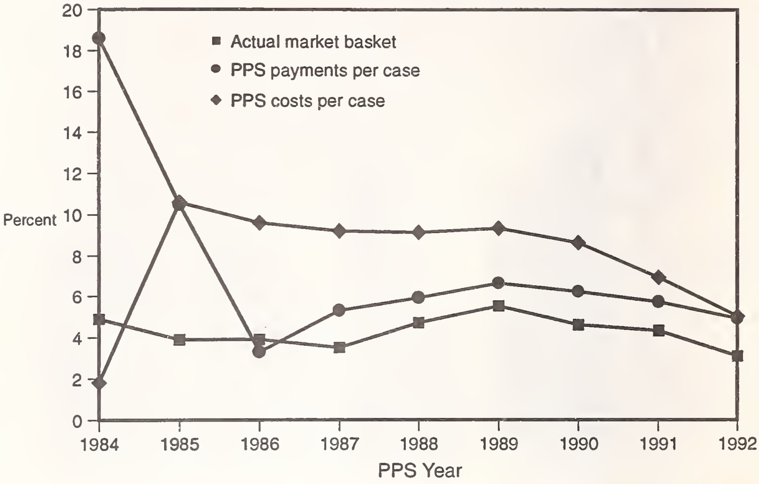
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 2. Medicare Benefit Payments, by Sector, 1991 and 1993 (In Millions)

Sector	1991 Expenditures	1993 Expenditures	1993 Share of Total	Annual Percent Change 1991-1993
Total Medicare benefits	$120,497	$151,101	100.0%	11.8%
Hospital inpatient	65,123	79,012	52.3	10.1
Hospital outpatient	8,342	10,897	7.2	14.3
Physician	31,380	34,817	23.0	5.3
Home health	5,695	10,862	7.2	38.1
Nursing home	2,859	6,124	4.1	46.4
Other	7,096	9,388	6.2	15.0

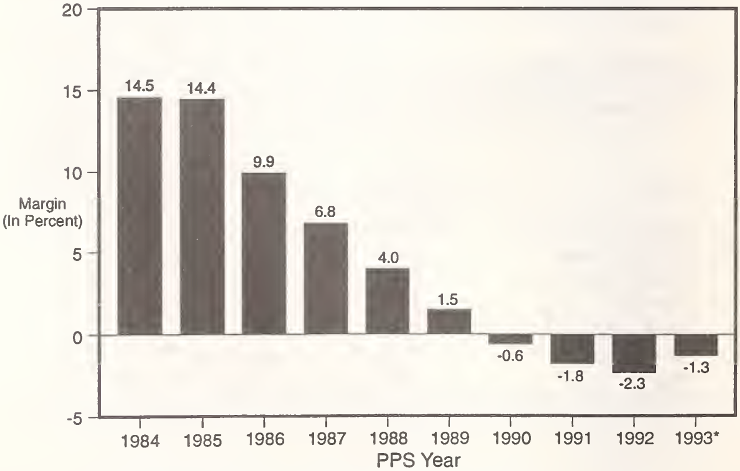
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 3. Annual Increase in Actual Market Basket and PPS Payments and Costs Per Case, First Nine Years of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

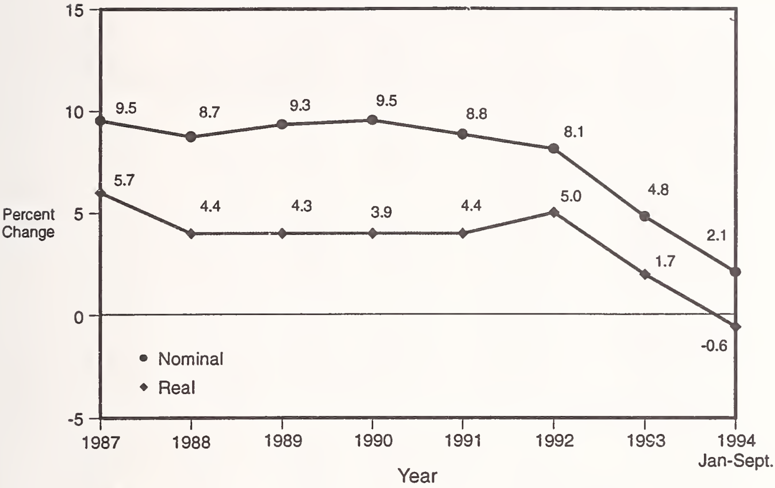
Chart 4. PPS Margins for All Hospitals, First Ten Years of PPS



* Preliminary data based on non-representative subset of all hospitals.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 5. Annual Change in Hospital Cost Per Adjusted Admission



Note: Value for January to September 1994 compared with same months in 1993.
SOURCE: American Hospital Association National Hospital Panel Survey.

Chart 6. Distribution of PPS Hospitals, Discharges, and Payments by Hospital Group, FY 1994

Hospital Group	Number of Hospitals	Percent of Discharges	Percent of Payments	Payments (In Billions)		
				Total	IME	DSH
All hospitals	5,251	100%	100%	$66.0	$3.8	$3.4
Urban	2,932	80	87	57.5	3.7	3.2
Rural	2,319	20	13	8.5	0.0	0.2
Large urban	1,609	45	53	35.2	2.8	2.1
Other urban	1,323	35	34	22.3	0.9	1.1
Rural referral	246	7	5	3.4	0.0	0.1
Sole community	576	3	2	1.4	0.0	0.0
Other rural	1,497	10	6	3.7	0.0	0.0
Major teaching	229	10	17	11.2	2.4	1.1
Other teaching	801	32	34	22.8	1.4	1.1
Non-teaching	4,221	59	49	32.1	0.0	1.1
DSH large urban	727	21	28	18.6	2.0	2.1
DSH other urban	621	19	19	12.8	0.7	1.1
DSH rural	458	5	4	2.4	0.0	0.2
Non-DSH	3,445	55	49	32.2	1.1	0.0
IME and DSH	609	24	32	21.1	2.7	2.2
IME only	421	18	19	12.9	1.1	0.0
DSH only	1,197	22	19	12.7	0.0	1.1
No IME or DSH	3,024	37	29	19.4	0.0	0.0
New England	225	6	6	4.1	0.4	0.1
Middle Atlantic	538	17	20	13.2	1.2	0.8
South Atlantic	749	17	16	10.6	0.4	0.6
East North Central	804	18	17	11.3	0.8	0.4
East South Central	459	8	7	4.4	0.1	0.3
West North Central	742	8	7	4.8	0.3	0.1
West South Central	740	10	9	6.1	0.2	0.4
Mountain	348	4	4	2.7	0.1	0.1
Pacific	646	11	13	8.8	0.3	0.6
Voluntary	3,006	74	76	50.0	3.0	2.2
Proprietary	751	12	11	7.1	0.1	0.3
Urban government	434	8	10	6.4	0.7	0.7
Rural government	1,024	6	4	2.4	0.0	0.1

SOURCE: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1992 MedPAR file from data from the Health Care Financing Administration.

Chart 7. PPS Operating Margins and Total Hospital Margins, by Hospital Group, 1992 (In Percent)

Hospital Group	PPS Margin	Percent w/ Negative Margin	Total Margin	Percent w/ Negative Margin
All hospitals	-2.3%	59.4%	4.3%	25.7%
Urban	-2.2	61.6	4.1	28.2
Rural	-3.0	56.7	5.0	23.7
Large urban	-1.3	59.3	3.5	25.9
Other urban	-3.6	64.3	5.2	21.1
Rural referral	-0.1	49.2	6.3	12.0
Sole community	-1.1	49.7	5.0	28.0
Other rural	-5.6	60.8	4.2	30.6
Major teaching	8.6	24.4	3.0	25.5
Other teaching	-2.4	59.9	4.3	23.2
Non-teaching	-6.0	61.2	4.8	26.2
Disproportionate share:				
Large urban	4.2	45.5	2.8	30.8
Other urban	-1.4	58.2	5.3	17.9
Rural	-1.2	47.5	6.8	20.1
Non-disproportionate share	-7.0	64.7	4.6	27.1
Payment adjustments:				
IME and DSH	4.5	41.8	3.5	26.0
IME only	-5.1	68.6	4.6	19.8
DSH only	-3.1	54.6	4.9	22.2
No IME or DSH	-8.3	64.1	4.7	28.0
Voluntary	-2.5	60.8	4.0	24.1
Proprietary	-2.1	54.6	5.7	27.6
Urban government	0.9	57.4	4.5	25.7
Rural government	-5.4	58.7	5.1	30.6

Note: Data for hospital cost reporting periods beginning during Federal fiscal year 1992. Excludes hospitals in Maryland and other hospitals with waivers from PPS. IME = indirect medical education. DSH = disproportionate share.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 8. Medicare Indirect Medical Education (IME) and Disproportionate Share (DSH) Payments, 1989-1994 (In Billions)

	IME Payments		DSH Payments	
Fiscal Year	Amount (In Billions)	Percent of Total PPS Payments	Amount (In Billions)	Percent of Total PPS Payments
1989	$2.2	4.8%	$1.1	2.4%
1990	2.5	5.3	1.6	3.3
1991	2.9	5.5	2.2	4.1
1992	3.1	5.7	2.2	4.0
1993	3.7	5.6	2.7	4.1
1994	3.8	5.7	3.4	5.1

SOURCE: Prospective Payment Assessment Commission, *Medicare and the American Health Care System Report to the Congress*, June 1989, 1990, 1991, 1992, 1993, and 1994.

Chart 9. Medicare Skilled Nursing Facility Utilization, 1980-1994

	Persons Served		Days	
Year	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 10. Skilled Nursing Facility Reimbursement Per Day

Year	Reimbursement	Annual Rate of Increase
1980	$47.5	—
1982	55.8	8.4%
1984	58.2	2.1
1986	70.9	10.4
1988	86.7	10.6
1990	98.4	6.5
1992	148.1	22.7
1994*	207.3	18.3

* Projected

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 11. Medicare Home Health Care Utilization, 1980-1994

	Persons Served		Visits	
Year	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	726	26	16,322	22.5
1981	948	34	22,688	23.9
1982	1,154	40	30,628	26.5
1983	1,318	45	36,898	28.0
1984	1,498	50	40,422	27.0
1985	1,549	51	39,449	25.5
1986	1,571	51	38,000	24.2
1987	1,544	49	35,591	23.1
1988	1,582	49	37,132	23.5
1989	1,685	51	46,199	27.4
1990	1,940	58	69,565	35.9
1991	2,223	65	100,044	45.0
1992	2,523	72	134,844	53.4
1993	2,900	81	173,953	60.0
1994*	3,220	88	209,149	65.0

* Estimated

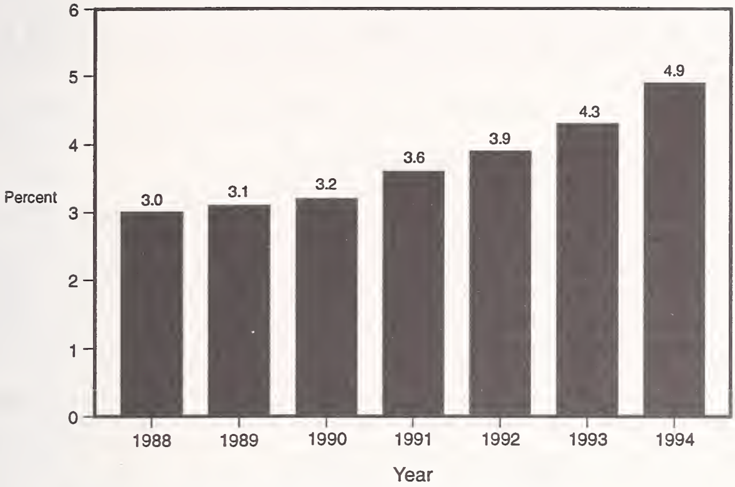
SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 12. Distribution of Visits Across All Home Health Users, 1992 (In Percent)

Number of Visits	Percent of Users
1-20	45.2%
21-40	19.2
41-60	8.9
61-80	4.6
81-100	4.4
101-125	4.1
126-150	2.8
151-175	2.2
176-200	2.3
Over 200	6.3

SOURCE: Health Care Financing Administration, Office of Research and Development.

Chart 13. Medicare Beneficiaries Enrolled in Managed Care Risk Contracting Programs, 1988-1994 (In Percent)



SOURCE: Health Care Financing Administration, Office of Managed Care.

Chairman THOMAS. Thank both of you very much. And, obviously, we have gone far beyond the usual 5-minute rule. But the points that you gentlemen have made after many years of examining the system in terms of alternatives, I believe are extremely important in enlightening and laying the groundwork for the additional panel members who will be held to the 5-minute rule and the members.

According to my notes, the first member to inquire will be Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Maybe both of you can address this a little further.

Volume increase seems to be the primary problem, as both of you clearly pointed out. Mr. Altman, you gave a couple reasons in the home health care and skilled nursing care, but maybe you can go further into some of the other underlying reasons why we are seeing such a tremendous increase in the volume. You mentioned it wasn't necessarily the increase in the age of the population, but what are some other reasons for this increase in the volume?

Mr. ALTMAN. We have had some subtle and some not-so-subtle changes in coverage rules over the last several years, partly generated by court decisions that required the Medicare program to liberalize their definition of who qualifies for home care, as well as freeing up the ability to go into a skilled nursing facility and stay there. I would think that, as much as anything, has led to the growth in the home care and skilled nursing care.

And, as I said, it was generated by the courts that said, basically, Medicare could not put in the restrictions that it had previously had. And so it sort of opened up the floodgates to the ability of individuals who—I am not saying they don't need it. The question is whether the need was as strong or is as strong as it might be, given the fact that this is an expensive service.

Chairman THOMAS. Dr. Eisenberg, could you address the rest of the system as well, some of the growth in volume?

Dr. EISENBERG. As we have looked at this, we have described seven different reasons for the volume increasing. One of them—two of them I have mentioned. One is the increase in the number of beneficiaries, 1.5 to 2 percent per year; the second is the increasing in the aging of the population. That is about 1 percent. The substantial part of the increase we believe has to do with the services that result from incentives in the fee-for-service payment system.

The third factor is the way in which the payment system is still constructed. Even though we are moving away from it, it is a system which pays more relatively for providing procedural services than for not providing those services. And so there is an incentive for physicians to provide those services just because of the way in which the rewards are set up in the fee-for-service system.

The fourth reason, which is related to that, is that physicians are able to increase the demand for their services—it is called induced demand—if they believe that more services might be justified or even if they are questionable. And in an unconstrained fee-for-service world, that has been a factor that has led to increases.

Technology is another. Technology cuts both ways, interestingly. We believe that one of the reasons why the rate of increase recently has been slowed is because of technological changes that have occurred in prostate surgery and cataract surgery, which have led during the past few years to a decrease in expenditures.

So technology can cut both ways, but usually it is a driver for increased volume. And a careful look at that technology and the way in which it is disseminated and the way in which it is used we believe could address that factor—for example, guidelines on appropriateness or outcomes research.

Another factor has to do with consumer cost sharing. At present, most Medicare beneficiaries have some kind of a Medigap policy and pay very little out of pocket. We are concerned about striking the right balance between not having beneficiaries liable for large expenditures that would bankrupt them, but on the other hand, having some fiscal responsibility on the part of the recipient.

Mr. ENSIGN. We have heard a lot about Medisave accounts in the context of the Medicare population. Do you see any way that the Medisave accounts can be incorporated into the Medicare population so there is incentive for them to shop?

Dr. EISENBERG. I think that the concept of the MSA, which enables the individual to put aside a certain amount of money so that the discretionary expenses which I am alluding to could come out of their own pocket, would probably be beneficial in that it would give them a deeper pocket effectively to pay for those expenditures, so long as there is some—we want to eliminate the possibility of catastrophic expenses or large expenses for those individuals.

It would take some time to build up an MSA that would be capable for paying for one hospitalization or one large procedure, so I think we would need to look with you at what the size of that MSA would be and what the risk ought to be, what the power ought to be, where the individual is protected against larger expenditures. I think it would be helpful.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. EISENBERG. The last factor is the overcapacity of the system.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

I would like to thank the witnesses. I just wanted to talk a little bit here about the numbers and the growth, just to make sure that we are all reading from the same page.

I'd like to ask Dr. Eisenberg and Dr. Altman both, it is my understanding that in the period from 1984 to 1993, as a comparison of private health insurance versus Medicare per enrollee, the annual rates of growth were lower for Medicare to hospitals, 6.1 to 7.7.

Do you agree with that Dr. Altman?

Mr. ALTMAN. If you go from the full period from——

Mr. STARK. 1984 to 1993, the annual rates of growth.

Mr. ALTMAN. I think if you added all them in, those three periods we have in chart 1.

Mr. STARK. I am just quoting from Bruce Lattig's stuff here from Health and Human Services on the annual rates of growth for private health insurance versus Medicare per enrollee.

Mr. ALTMAN. Is that for all services? I don't have——

Mr. STARK. Let me say that again. It is for hospital.

Mr. ALTMAN. Yes. I don't think there is any question that on the hospital side, the growth rate for Medicare—over that whole period has been less.

Mr. STARK. Thank you, and the same thing is true for physician reimbursement, Dr. Eisenberg. I have 7.9 percent for Medicare versus 11.2 percent for private.

Does that ring correct with you?

Dr. EISENBERG. 11.2 percent in which period?

Mr. STARK. 1984 to 1993, the last 10-year period for which we have numbers, that the private health insurance versus Medicare per enrollee, that the growth in expenditures was 7.9 percent for Medicare and 11.2 percent for private insurance.

Does that comport with your figures?

Dr. EISENBERG. It sounds right. I don't have the data in front of me.

Mr. STARK. What I am trying to do here is just reclaim a little of Medicare's rightful credit for being what I will call the most efficient health reimbursement system in the United States today.

I want to take it a piece at a time. There are some flaws, no question, but it is my understanding that the recent unusual growth that we have had in the last 2 years has been largely on the side of home health care in skilled nursing facility services, not in physician-hospital reimbursement.

Would both of you agree with that premise?

Dr. EISENBERG. Yes.

Mr. ALTMAN. That is true.

Mr. STARK. So what I guess I am saying is that we have, largely with the help of the organizations that you two gentlemen represent, over the last 10 or 12 years, done a pretty credible job of holding down the reimbursement growth for physicians and hospitals.

There has been a lot of disagreement as to whether we are paying rural hospitals enough or teaching hospitals enough or surgeons more than primary care, and we have debated that in this committee for—long and loudly.

But I do not know of an insurance or payment scheme in the United States that has a lower overhead than Medicare. Do either of you?

Mr. ALTMAN. Not that I have seen.

Mr. STARK. Dr. Eisenberg.

Dr. EISENBERG. No.

Mr. STARK. All right. Now, you may know this or not, but I would further say that there is no health insurance operation that has a lower rate of employees to beneficiaries.

We have around 4,500 bureaucrats, somewhat less, in HCFA and Medicare and in Baltimore working on Medicare, and we have 35 million beneficiaries, and I do not know of a private operation, be it Kaiser Permanente or anybody, that has a lower ratio of administrative personnel to beneficiaries.

Do either of you know of any?

Dr. EISENBERG. No.

Mr. ALTMAN. Well——

Mr. STARK. Even Georgetown, Dr. Eisenberg?

Mr. ALTMAN. I think it is only fair that in doing that calculation, we should include the amount of money we spend for the intermediaries and stuff, and so we would have to look at it.

I just don't know what——

Mr. STARK. That includes the intermediary fees.

Mr. ALTMAN. Does it?

Mr. STARK. Yes, but not the overhead, but not in the personnel. You are right. We do contract out.

Mr. ALTMAN. I just—we need to do this fairly, and I just don't know. I haven't looked at the numbers.

Mr. STARK. The only other question that I would raise in whatever limited time, and this would go to Dr. Eisenberg, is that we did, after a long debate, a lot of hard work and soul searching here, revise the manner in which we paid physicians, and it was a Republican administration that proposed the payment structure. It was proposed by some doctors' groups and opposed by others. It has been adjusted once I think in major legislation since we put it in, and it is working marginally, but it is working. It is running. It starts on a cold morning.

Many health insurance—private health insurance companies are copying it. In California, Blue Cross uses it with a resource-based relative value system. Do you think that we should be very cautious in amending or changing any contract with the physician community lest we lose our credibility in being able to work with them and end up like the baseball players and owners? And I ask that as your personal opinion as a physician.

Chairman THOMAS. In a word, Doctor.

Dr. EISENBERG. In a word. Medicare led the way in changing physician payment and did so in a fashion which I think was fundamental and very, very important and very salutary in improving physician payment and it is being picked up by the private sector.

The question today is not, I think, whether the RBRVS needs to be overhauled. I didn't hear very many people talking about doing that, but rather how we deal with the conversion factor and the rate of increase in volume so that Medicare, which led the way for the past 5 years, can now benefit from what is happening in the private sector to enjoy continued savings.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Altman, would you agree that Congress' attempt in 1993 to contain hospital costs by limiting payment increases to two points above the market basket may not have impinged much on hospital margins at all because the actual rates in hospitals did not achieve the rates the market basket model predicted?

Mr. ALTMAN. It was 2 percent below market basket. What happened prior to this year is that Medicare has put very tight limits on what it pays hospitals.

Hospitals' costs have been able to continue to grow at their PPS rates because they were able to shift onto private patients higher and higher extra payments so the hospitals didn't feel the pressure from the Medicare payments and Medicare didn't feel it.

It was kind of the best of all worlds for the government. It could establish lower and lower rates and nobody felt it, except, of course, the private payers, but beginning in 1992, 1993, and particularly 1994 and 1995, the private payers are no longer paying these higher rates and so that is why we are seeing the reduction in hospital costs for the first time.

Mr. CHRISTENSEN. If the current hospital inflation rate remains what it has been, what effect do you see by limiting the hospital payment increase to minus 2 percent of the market? What will we have in the future?

Mr. ALTMAN. If the hospital cost structure continues on its current path, which is 1994, 1995, then the minus 2 percent will not be as serious a problem. If it would have jumped back up to what has existed prior to 1992, then hospitals are going to have one serious problem.

Mr. CHRISTENSEN. You stated earlier in your testimony that there is a problem with the market basket index.

Mr. ALTMAN. Yes.

Mr. CHRISTENSEN. In terms of predicting the future prices for goods and services that hospitals purchase, do you have any suggestions on how we can make them more accurate?

Mr. ALTMAN. We have been shocked is probably too weak a word by the gap that has—we just did a study last month and looked at what was forecasted for the market basket next year and what actually the market basket was and that gap has gotten very wide.

As an economist, I am sort of a little chagrined that my fellow economists have done such a poor job in terms of anticipating what has been going on in inflation. But now I can see why the bond market and the derivatives got into so much trouble.

So our recommendation is we should not—we don't need to be quite so futuristic and we should be adjusting, once we realize what the true market basket is. As it has turned out, the program has overpaid hospitals in the last couple of years because it used a market basket that was significantly higher than what true inflation was.

But to be fair to hospitals, though, the whole procedure that the Congress uses by having that minus 2 percent below the market basket on average probably worked out OK. In other words, we sort of had countervailing mistakes.

So when you look at what the hospitals actually received from Medicare and what it turned out to be, it is very close to what their true cost increases were. But I will tell you, it is a very dangerous way to sort of have countervailing mistakes. I would rather see us adjust after we realize what the true numbers were.

Mr. CHRISTENSEN. During the ranking minority member's comments, I heard him laying the foundation for his belief that big government knows best how to run Medicare and should be allowed to take over everyone's health care.

It is not your philosophy that government knows better how to run the health care system better than the private sector, is it?

Mr. ALTMAN. No.

Mr. CHRISTENSEN. I didn't think so.

Mr. ALTMAN. I think the balance is—you know, it is that tricky balance here, but for the most part—to be fair to everybody here, there have been times when Medicare, as Dr. Eisenberg has pointed out, where Medicare has been ahead of the game and the private sector borrowed from government. But the government has gotten behind the curve and it is way behind the curve in some very major areas.

Mr. CHRISTENSEN. We have to be reminded that the American people resoundingly rejected the big government philosophy on health care last year, and I would remind the ranking minority member that big government doesn't know best when it comes to health care in America.

Chairman THOMAS. Thank you.

Mr. Lewis will inquire.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Let me thank members of this panel for being here this morning.

Dr. Altman, if Congress adopts the recommendation to cut IME and some other requirements, what would that mean in terms of caring for the uninsured? Would that simply put more of the costs on the back of local government? If it does, then are we saving any money overall or simply transferring the cost?

Mr. ALTMAN. Mr. Lewis, we at ProPAC have been very concerned about both the preservation of teaching hospitals in this country and in making sure that there is adequate money for the uninsured and others in urban and rural areas.

The question becomes whether the teaching hospitals, like every other sector, can reduce its costs, not cut care. I have lived in Boston for a long time. You know that Boston is the citadel of—let's say a major—a number of major teaching hospitals in this country, and for a long time there was absolutely no give on their parts in terms of recognition that they needed to cut their costs.

We are seeing some extraordinary things happen in Boston, merging of teaching hospitals, affiliation agreements, cutbacks. So, you know, to be honest with you, I don't know where those numbers are going to come out. But I tell you, I think we can anticipate, if we are tighter with that teaching adjustment, that we can do it without affecting negatively quality and access. I think we ought to monitor it very carefully.

I don't think we ought to be blind to this, but I don't think we should just establish what used to be. We were paying those hospitals too much. So that is why we recommended reducing it in stages and watching to make sure that we don't do harm, because we share your concerns. We really do. I do.

Mr. LEWIS. Dr. Eisenberg and Dr. Altman, can you address payments by private managed care companies and how those payments relate to Medicare payments? In other words, is Medicare paying as well, worse than, or equal to managed care in the private sector?

Dr. EISENBERG. It is a—from a physician payment perspective, it is a moving target. The data that we have analyzed in the past suggests that Medicare pays somewhat less than most of the managed care programs who use the resource-based relative value scale.

That is to say, their conversion factor is higher than that of Medicare's, but it is changing. They are becoming much more competitive and the negotiations between the providers and the managed care companies are leading to those conversion factors dropping further.

So I—as I said earlier, I think at the beginning, Medicare was ahead and now the private sector is catching up and in many cases moving further ahead than the Medicare plan.

The other issue with managed care programs is that this comparison can only be made for those managed care programs who continue to pay physicians fee-for-service. You can't really draw that same comparison when the managed care plan capitates the physician group, in which case it is really a different way of paying and can't be compared very easily.

Mr. ALTMAN. With respect to hospitals, I can tell you what we know and then I can tell you anecdotally what we think because our data which runs through 1992, 1993, suggests that the private sector is still paying significantly more than Medicare.

I know situations where Medicare is actually paying certain institutions more than the private sector, particularly rural hospitals, disproportionate share hospitals and teaching hospitals. Not in all cases, not in all areas, but there are examples where Medicare has become the better payer.

Mr. LEWIS. This is not necessarily related to the issue that we are considering today, but I would like to hear the two of you respond. Wouldn't you agree that the debate, the discussion that we had last year on the whole question of health care reform was a necessary debate and it did move the private sector on toward health care reform?

Dr. EISENBERG. Well, I think first it was a very fruitful debate because it did lay out a number of the options, which we are still considering today, and in that way, was really quite constructive, and yes, it did move the private sector.

I think it was in many ways a wake up call to the private sector, both providers and the purchasers of care, that they needed to look more carefully, both at the prices and at the volume of services that they were dealing with.

Mr. ALTMAN. I am a long-term-trend guy and I think most of what you are seeing today was started a long time ago. I am not—I don't really know how much of it was a result of last year's debate.

I would like to think it was a positive. I have been watching the private sector for a long time, and I was surprised how long it took. I kept waiting for these numbers to come down because I have been part of this managed care environment in certain ways for a long time.

So I don't think there is anything that happened in 1994 and 1995 that was totally unique. How much of it was kick started or expanded, I don't know, but we are dealing with long-term trends that started in the seventies and more importantly in the eighties, I think.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Lewis.

Mr. Houghton will inquire.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Gentlemen, thank you very much for being here. I have got two categories of questions. The first is specific, three specific questions, and if it is too difficult to answer them now, maybe you could just send us some answers in writing.

The first is the Physician Payment Review Commission. If I understand it, originally there was sort of—it was sort of one standard which was suggested. Now you have two or three standards. Are there distortions because you have multiple standards rather than just the single one you had before? Now, that is number one.

Number two, I live in New York State and New York State has got a couple of problems. First of all, it has been under constraint, because of a variety of pressures, to keep the hospital costs very low, and I am afraid those people who did a good job earlier may be suffering because of new standards which will be put on by the Federal Government.

And second, in terms of managed care, it is a good idea. As a matter of fact, one of the heads of the Catholic hospital, a nun, had suggested we do away with fee-for-service. That would be the greatest thing that could happen to them. But if we are going to move on the managed care route, it is very difficult in the rural areas.

So those are three specific questions, and any way you can help me on that, fine. And if the answers are too long, because I do have a more general question, then you can send some—send them in writing.

Dr. EISENBERG. I will try to be brief. On the three standards, yes, it is a distortion, and PPRC believes that it undermines the basic premise of the resource-based relative value scale, and we have always suggested that there be a single standard. And we can provide you with more information on that.

One of the difficulties with areas like upstate New York with regard to managed care is, number one, that you did have a lower rate of increase in many parts of New York—upper New York State, and that has made the AAPCC or the calculated amount that the Medicare plan will pay the managed care organizations lower, a serious disincentive for managed care programs to move into areas that had a historically successful limited rate of increase in their expenditures.

And finally, with regard to rural areas, we are concerned about the availability of managed care in rural areas and are thinking through some ideas about ways in which we can make it more accessible and would like to pursue that with you further.

Mr. HOUGHTON. All right.

Mr. Altman.

Mr. ALTMAN. On the hospital side, New York—I am an ex-New Yorker and I spend a lot of time looking at New York. New York is unique.

Mr. HOUGHTON. I think your accent says that.

Mr. ALTMAN. Only you could pick that up. I try. Anyway, New York has been able to keep the price per visit or admission down, but the length of stay in New York is the highest in the United States. Admission rates to hospitals per 1,000 is the highest in the United States. The number of beds per person is the highest in the

United States. New York needs a capacity shrinkage and it is beginning to go through it.

I think managed care is going to have a field day in New York. And it is beginning to—you can see it in the city. There is an awful lot of—I don't want to say waste, but there is an awful lot of potential for savings in New York and you are going to see it happen.

So, Medicare—of all of the places in the United States where Medicare is behind, it is in New York. The difference between New York and California is phenomenal, and I would be glad to give you the data that I have on it, but you are going to see New York go through a very substantial change in the structure of its health care system over the next 4 or 5 years. I am sure of it.

Mr. HOUGHTON. I would like to have you break that down a little bit because there are many things——

Mr. ALTMAN. And obviously there are different parts of New York.

Mr. HOUGHTON. Right, and the question is this. I will shoot it out. I am almost out of time. Are we moving in the right direction? How long can we continue to patch up this system? And in the process, are we really falling behind? I really worry about that.

Dr. EISENBERG. I believe that what we ought to do is to try to develop a financing system which will provide the incentives to physicians and hospitals, and in the case of Medicare beneficiaries, to develop responsible relationships that would move toward their participation in integrated systems of care, and managed care will help us to do that.

Some changes in the way in which we pay in Medicare will help us to do that, but we are not sufficiently or quickly enough moving in the direction of developing these systems that are integrated. It is happening in the private sector, but I don't think that Medicare, as it is currently constructed, helps that to happen as much as it could.

Mr. ALTMAN. Mr. Houghton, I think the patchwork is not only Medicare. The patchwork is our health system. We have a gigantic Ponzi game going on right now where there is all this money being moved around.

Teaching hospitals are being subsidized because they are not getting adequate money for research, so they are grabbing it from patient care. For-profits get it from one sector, not-for-profits from another sector.

The problem I see is that if you start dealing with one sector and you squeeze down on it, the potential for it to balloon up in another sector has been very real.

Medicare was ahead of its time and then went behind its time. Medicare needs to become a much better managed care plan, even within the existing law. It can manage itself better by introducing some of the kind of changes that the private sector has, without necessarily putting it outside.

But the fear I have is you have a delivery system which is playing against a set of inconsistent incentives and we need to be careful about that.

Chairman THOMAS. Thank you.

Mr. McDermott will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Sometimes—it is good to see both of you. Old friends. Sometimes I think your answers are a tad polite or maybe tailored to who asks the questions, so I want to ask a question from another point of view.

Dr. Eisenberg, I want to really clarify what you said about medical savings accounts, given the various studies that exist that show that widespread use of them will undermine the financing of the health care system because it destroys the idea of risk pool. My feeling is that medical savings accounts discourage use of preventive medicine or any kind of routine things, and I would like to hear a little more. It sounded like you thought medical savings accounts might be a good way to go.

Dr. EISENBERG. Well, my comment was in the context of Mr. Ensign's question about the degree to which Medicare beneficiaries pay anything out of pocket when care is received, and whether or not MSAs, medical savings accounts, or anything like that might help them to be able to pay those copayments or deductibles, and I do think that for the elderly, an account, whether you call it an MSA or a bank account, from which they could pay a copayment or a deductible would help to add a level of beneficiary participation in the payment system.

I don't think that an MSA by itself would be sufficient, but I don't think that was the context of his question. It was more how can we help people to be able to pay a copayment so there is more participation in the payment by the elderly.

Mr. MCDERMOTT. OK, then what you are saying is that widespread use of the medical savings accounts would, in fact, not be a good idea?

Dr. EISENBERG. Well, that is a different question, but I would—first let me just say that PPRC has not studied the MSA proposal, but I think that what we would suggest is given the Medicare program, that an MSA might be an alternative to help the elderly pay those out-of-pocket expenses, so long as, as I mentioned earlier, there are adequate controls for catastrophic expenses.

Mr. MCDERMOTT. Thank you.

Dr. Altman, you mentioned in your written testimony about medical schools or it was Dr. Eisenberg who talked about them. I am not sure everybody on this panel knows, but I checked the University of Washington. Eleven percent of the money for the University of Washington comes from the State legislature, 39 percent comes from physicians' income, and 50 percent comes from Federal grants of one sort or another.

How much can we reasonably cut into Medicare without doing significant damage to the medical schools in this country? There is some suggestion they have been overpaid in the past, but I would just be interested in hearing you and Dr. Eisenberg talk about what happens to medical schools if we go in and make the kinds of cuts that the Contract With America really makes necessary to balance the budget.

Mr. ALTMAN. Well, as I indicated to Mr. Lewis, I think the issue really gets down to the ability for medical schools to restructure, to make significant savings in the way they do business, just like other hospitals have done and other institutions.

And we just don't know to what extent those savings can happen, but we do know the direction, and therefore, I don't think—personally I don't think we need to buy into the idea that what we paid yesterday is what we have to pay tomorrow.

On the other hand, I am very concerned about medical schools and what they have traditionally provided us, that we just don't wholesale cut them. And so that is why we have tried this middle ground of not going down 3 percent, as some have suggested, going down gradually. If you look at our total recommendation, there are a number of areas where we have recommended an increase to medical schools.

For example, our better outlier policy recommendation allows them to get payments when they really do treat sicker people. So I think medical schools, by their necessity, have been the last of the hospitals to get into this cost cutting mode, but I think when they get finished with it, they are going to have a cost structure that could allow perhaps significant reductions in payments because they are going to have to survive a private sector which is being very tough on them. I don't think the government has been nearly as tough on medical schools as has been the private sector which wants much more for their money.

Dr. EISENBERG. There clearly are cross subsidies of one activity for another in medical schools, and recently medical school faculty practice plans have been developed accounting for up to half of the medical school's revenue because of the fact that that revenue is so critical to pay for the teaching and research activities of those faculty.

And certainly as Medicare reimbursement decreases, if the other sources for paying for teaching and for research also decrease, then you are right, the medical schools and their associated hospitals will have serious problems, and we need to look at that.

I am at least as concerned about what happens to the medical schools in a more competitive environment where those cross subsidies are not available and particularly in a managed care world. If Medicare does move to more managed care, then we need to look very carefully at the degree to which those managed care plans choose to work with teaching hospitals, because frankly, a reduction in Medicare payments of the amounts that you are discussing aren't as bad as losing all of the Medicare patients to a managed care plan that decides not to use a more expensive institution or one which has some of these other costs that it needs to take on.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Sam Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Altman, you alluded to the fact that home health care services might be bundled perhaps in a managed care type risk contract program.

Can you elaborate on that a little bit, and are there any other options? That is, can we get the private sector more involved?

Mr. ALTMAN. I think it can—as I indicated, we in my research capacity had the government create a—what is called a social HMO model. We had it in California, in Oregon, in New York and Minneapolis, and what we did is we gave these private sector systems a capitated amount and required them to provide, in addition to acute care, also home care, and as a result of that, they were able to manage their home care and skilled nursing care much better than the Medicare program and fee-for-service could do.

So I definitely see the potential for creating either a fully capitated system, or a minicapitated system which focuses on home care and other what are called postacute care services. I don't think it ought to be only home care.

There are a lot of tradeoffs between home care and skilled nursing facilities, rehab centers, and even some outpatient services. So I see the potential for substantial savings under such a structure, yes.

Mr. JOHNSON. Well, you know, the way you are describing it, we are kind of micromanaging it from the government level.

Is there some way we could actually contract with the private sector?

Mr. ALTMAN. Absolutely. Right now we are not managing it at all. It is a fee-for-service system and there are some very loose safeguards built in, but the growth rate suggests there is not a lot of management going on at all.

Mr. JOHNSON. I thank you, and in the teaching which we were talking about in the previous question, can you tell me—you know, you said they would move the money around once they got ahold of it. How do you keep them from doing that if you more or less grant them the dollars?

Mr. ALTMAN. I don't want to do that. I am saying that right now what is happening is we have a total health care system which underpays and overpays. We have 40 million Americans with no health insurance, yet we provided them with 12 billion dollars' worth of free care last year. Somebody paid that bill.

We have Medicare which pays some hospitals 80 cents on the dollar and some hospitals 110 cents on the dollar. We have other Medicaid, some States are paying 60 and 70 cents on the dollar. Those institutions then go to find money from somebody else. So there is a lot of money.

Now, in the old days there was a lot of extra money sloshing around and we didn't worry about it so much. But in this new environment, both on the private side and the public side, there is not a lot of money sloshing around so therefore I think we are going to have to focus those dollars a lot better and decide from a public policy point of view how many teaching hospitals do you want, how many residents do you want to train? So it is not just Medicare. It is much more, I think.

Mr. JOHNSON. Every now and then I hear even the doctors say there are too many doctors. Have you done any studies on that issue?

Mr. ALTMAN. Well, that is me talking, you know, in an area—I think I will let Dr. Eisenberg respond.

Dr. EISENBERG. Thank you, Stuart.

PPRC has looked at this issue and we believe that there will be, if there isn't already, a surplus of physicians and as we move to managed care, which uses both less physicians and a different mix of physicians, fewer specialists, then we believe there will be an excess of over 100,000 physicians within a few years and that most of those physicians will be in the specialties that are currently overpopulated.

Mr. JOHNSON. Is that fairly evenly divided across the Nation or is it in specific urban centers?

Dr. EISENBERG. It is mostly in urban centers, although there seems to be a different distribution of primary care physicians than there is a distribution of specialized physicians.

Mr. JOHNSON. So wouldn't that then accrue to a reduction in teaching hospital dollars as well?

Dr. EISENBERG. It could if we reduced the total number of trainees. But the problem is we have approached this by reducing the dollars per trainee in the past rather than decreasing the total number of trainees so that the hospital then doesn't have the money that it believes is necessary to train each of the individuals it is responsible for. But we end up with too many hospitals doing the teaching and too many trainees in those training programs.

Mr. JOHNSON. Thank you, sir.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson of Texas.

Mrs. Johnson of Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Currently HMOs have to meet certain conditions to qualify as a risk contractor. Do you think the conditions currently required are appropriate? Are there impediments that limit the number who participate? Are there impediments Congress should look at to expand the number of HMOs that could function as risk contractors?

Dr. EISENBERG. Let me start. In our testimony, we suggested that there were several steps that needed to be taken in order to improve the ability of managed care programs to accept those risk contracts, including corrections in the way in which the current AAPCC is calculated, but perhaps being even bolder and looking at new ways of setting an appropriate price that Medicare would pay managed care organizations through, for example, a bidding process. We have a series of suggestions to offer to you that we believe would make Medicare a more attractive option for managed care organizations.

Mrs. JOHNSON. I will be very interested in talking about the bidding issue with you in greater length at some other time because I think just in the AAPCC it is going to be really difficult and for the same uneven estimates that we currently have.

Mr. ALTMAN. Mrs. Johnson, I go way back in the Medicare, as well as the general HMO system back in the early seventies, and I opposed then and continue to oppose many of the restrictions that are in them.

I think that we have tried to recreate too many restrictions across the board. For example, the idea that Medicare risk contractors have to provide more services, there ought to be a way where the beneficiary might benefit more from a reduction in some price where a Medicare HMO could decide whether it wanted to have a benefit increase or a price increase.

Also, I think the program ought to be able to benefit, and some of these services that we have mandated, I am not so sure they are all that necessary in every place. I think it might be of some value in having Medicare HMOs that have different service compositions.

I am not in favor of one service benefit for everybody. I think we benefit by choice, and so I have opposed them over the years—I believe that there are too many restrictions.

Mrs. JOHNSON. Thank you.

That is very helpful and if you could follow up with more on that subject and if you could help me, Dr. Eisenberg, in how we get a bidding system in place properly. I think that would be very helpful.

[Due to its size, the information is being held in the committee files.]

I think for us to try to amend the current structure which we know has weaknesses and we know through an amendment we can't address those weaknesses except on a temporary basis is spinning our wheels. I would like to look at the bidding system and how we could put bidding in place, and I certainly would like to free seniors to be able to have the choice between increased benefits and lower price, which they don't currently have.

I think those two things in a voluntary opportunity for seniors to participate differently in their own health care choice would radically alter the circumstances and probably improve both the quality of services Medicare provides and reduce costs.

Let me just ask, what is your experience with the social HMO project? Is there anything we can learn from the social HMOs in redesigning the home health benefit, which we know is one of the real cost drivers of current increases?

Mr. ALTMAN. Well, as I indicated, I think the thing that we learned the most from the social HMO is by giving a managed care plan a broader responsibility with slightly higher payments, in this case we went up from 95 to 100 percent and we also allowed them to get extra payments if these people would have been institutionalized, they were able to manage their services better. They were able to choose between home care and more hospital care, between home care and skilled nursing care better than a fee-for-service add-on.

Mrs. JOHNSON. And from that demonstration project, would it be possible this year to nationalize that system?

Mr. ALTMAN. I think so, and I have asked several times for substantial expansion. Now, the Congress did give the HCFA authority to expand by three or four new programs. My own view is it should be expanded much more. It has shown itself to be a valuable addition.

There are problems with it. It didn't work perfectly in all areas. New York had more of a problem than California, but that was as much related to the AAPCC. So, yes, I do believe that there is potential growth in the managed care world to manage particularly home care and skilled nursing care much better than a fee-for-service system.

Mrs. JOHNSON. Let me just correct the record. I didn't mean nationalize. I meant nationwide.

Mr. ALTMAN. That is what I meant too.

Thank you.

Chairman THOMAS. The gentleman from Washington had a brief shining moment there where he thought he had you. You caught him on the correction. I want to thank both of you for your testimony, especially the specific suggestions that you have made.

Dr. Altman, and Dr. Eisenberg, the discussion with the ranking member, I think was useful in terms of a look back, that is, in the period from 1984 to 1993. We did make some changes which gave Medicare a comparative advantage in the short run.

I think, though, going back to the charts that you showed us, if we look more recently, we have seen that those items that have begun to take hold in the private sector have, in fact, begun to outpace the ability of Medicare to change and I, like you, am a believer in long-term trends.

I remember it was about 2 years ago that you and I were sitting here agreeing that we thought these changes were not temporary, they were long-term, and therefore the folks in the administration and the last Congress had to completely restructure it because any downward trends are really blips and that no one is going to tell us it is not going to go back up again, when clearly I thought we were locking in place some long-term changes and were beginning to see it.

I especially liked both of your testimonies indicating that we can no longer put items on what amounts to automatic pilot, a 5-year change or a 7-year change because frankly in that 7-year period, at least the part A trust fund is projected to go bankrupt. And so it is a 1-year or a 2-year adjustment of various programs until we can rethink the whole structure, and a 10-year look back is nice, but it is just that. It is just nice.

The gentleman from Washington talked about 50 percent of the Federal dollars funding the University of Washington, which I firmly believe, although I don't think it is all on Medicare's back. I think NIH funding grants and contracts are involved there as well, but it gets back to I think a fundamental point, and Dr. Eisenberg, I want you to respond to it briefly, and that is, although hospitals still are the 52 percent, the major funding aspect, clearly the trend is less and less inpatient hospital funds available and more and more, for example, outpatient.

I think in your testimony you talked about moving medical education more toward the ambulatory part of the activities, and doesn't it mean then that what we have to do is perhaps not be alarmed about the funding aspect of hospitals under Medicare if it continues to shrink, which I believe it will because of long-term trends, but that it means we have got to rethink the way in which we fund medical schools, not just the total dollar amounts, but the direction of the dollar amounts, perhaps providing the students with more of an opportunity to have an influence over the education that they get, a bottom-up approach to funding rather than the top-down structure that we have.

Any reaction to that?

Dr. EISENBERG. I think that that kind of flexibility would be a major step forward because it would unleash the medical student or the resident, and in Medicare's case, we are really talking about residents from the site of care, so that education wouldn't necessarily have to be linked with the hospital or even with the place where the care is being rendered.

I think that would be a big step forward and PPRC would like to work with you to think about ways in which we can do that.

Chairman THOMAS. When I say students, I mean it in the larger sense of the word. I think I am an ongoing student as well.

The gentleman from Washington have a comment?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I would just like this one brief question of Dr. Altman.

Would you comment on the feasibility of providing outpatient services under some kind of PPS or DRG kind of system as a cost-saving mechanism that would provide cost savings, but still guarantee people the right to choose?

Mr. ALTMAN. Well, first, we have been trying to develop a partial PPS-type, DRG system for outpatient services. It turned out to be very hard because you are dealing with hundreds of thousands of different diagnoses, people moving from one group of providers to another on different days, you can't measure it.

So there are 10,000 reasons why it is a bad idea, but I think in general it is a good idea that still needs to happen and the way one needs to do it is to bundle it into a bigger set of categories. You can't do it the way you have done the hospital-based DRG. It just won't work, and therefore you need to go to some form of partial capitation maybe.

You don't need to capitate total services. You could capitate all outpatient services to a group of separate individual entrepreneurs or not-for-profit firms, but what won't work to save you a lot of money is a partial DRG system for outpatients, much as I would like to see it done, and the staff and the people at HCFA have convinced me it is a very complicated thing and it is likely to fail. So therefore I would jump over that and go to partial capitation or complete capitation.

Mr. MCDERMOTT. Dr. Eisenberg, do you have a comment?

Dr. EISENBERG. We also are enamored of the idea that partial capitation might be a reasonable way to move as we try to get Medicare more involved with the managed care options. PPRC has not looked at the outpatient departments of hospitals though, and so I can't really speak to that issue specifically.

We do believe that we ought to move more in the direction of considering different ways of bundling services though. As an example, this committee asked the Commission, Mrs. Johnson specifically, to look at the issue of trauma care, which is an amalgam of contributions from a tremendously diverse group of providers and our conclusion was that paying a global payment or a bundled payment for trauma care would also be a reasonable way to reconsider the payment for that service.

So I think the idea of paying bundled or a global payment or trying to move it toward a capitated model makes good sense.

Mr. MCDERMOTT. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Mr. Altman, you talked about the need for volume control and you indicated the two growth areas, home health and nursing home, although clearly not approaching the dollar volume of other areas. The 46.4-percent growth in nursing home is certainly something to focus on, as well as the 38-percent growth in home health.

In terms of some specific examples, I have seen some on home health in terms of copayment examples. Can you give me any indication of what the effect might be of a 20-percent coinsurance or a copayment on the first 20 days of the skilled nursing facility benefit? Would that have an impact on the utilization?

Mr. ALTMAN. I think we have to recognize that most of the Medicare beneficiaries have some form of extra insurance, Medigap of some kind, so I think the impact on the program, the program would save substantial money.

I think the impact on utilization would be quite limited, and so I support a—some form of coinsurance just as a general policy for home care, but I don't think it is going to have a substantial reduction in utilization, although I do think it will save the program money, but I do believe we need to go more toward a managed care. I think it will work better.

Chairman THOMAS. I thank both of you. We can continue to make changes inside the program that would save the program costs, but we really have to focus on reacting to the world as it is, and the world as it will be so that this program won't be just a cost-effective one, but it will be a utilization-effective one as well.

We appreciate very much your testimony.

Mr. ALTMAN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. If I could ask the second panel to come forward. Michael Mangano and William Scanlon. The subcommittee welcomes both of you to the hearing, Mr. Mangano as the Health and Human Services Principal Deputy Inspector General. Mr. Scanlon is the Associate Director of the General Accounting Office.

We look forward to your testimony. Your written testimony will be made a part of the record and you may proceed for 5 minutes however you may see fit and we will begin with Mr. Mangano.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. OK. Thank you very much, Mr. Chairman. It is always a pleasure to testify before this committee. I would like to limit my oral remarks to three primary initiatives that we have launched in the Medicare fraud and abuse area and finish up with a strategy that might help us in that battle.

We devote a significant amount of time to the Medicare program. It is very easy to understand why. With a budget this year of $178 billion, there is a lot of money to look after. That is about a fivefold increase since the eighties. The major initiatives I want to talk about are home health services, nursing homes, and medical equipment and supplies.

I want to begin with the home health area. As you can see from the chart over there, the home health care services have really exploded over the last 4 years. In 1990, we were paying $3.3 billion in Medicare for home health services, and by 1994 it is up to $12 billion. We anticipate that cost to go up to $16 billion this year and $22 billion by the turn of the century. The number of beneficiaries have also increased by about 72 percent since 1990 from 1.9 to 3.3

million, while the average number of visits per person has increased about 80 percent, from 36 in 1990 to 65 in 1994.

There are a number of factors that play into that. First, the increasing aging of the Medicare population. Second, new technology that can now be delivered in the home, and third, recent liberalizations of the home health care benefit.

We are finding several types of fraud and abuse in the home health care area, including cost report fraud, excessive services, or services not rendered, use of unlicensed or untrained staff, falsifying plans of care, kickbacks, and physicians actually not signing plans of care.

Let me briefly describe one example of a recent audit we just completed down in south Florida. In that example, we found that 75 percent of the claims submitted to Medicare, or 26 million dollars' worth, did not meet Medicare guidelines. Twenty-one percent of the visits claimed were not made. Twenty-nine percent of the persons were not homebound. Twenty-three percent of the physicians denied authorizing the visits and 2 percent of the beneficiaries did not want the services.

Second, let me move on to the nursing home area. The nursing home benefit for the Medicare program provides for 100 days in a skilled nursing facility. In 1993 the part A portion of that was $5 billion. But we are beginning to see more and more money moving into part B, which in 1992 is about $4 billion. Those services under part B could include things like physician services, laboratory and radiological services, medical equipment, and supplies. This cost shifting from part A to part B is very significant. The kinds of things that we would have anticipated that the nursing homes would have provided under part A are now beginning to show up more and more under part B.

There is a great incentive for the nursing home to have items and services billed under part B because it relieves them of the expense and the management of those services and beneficiaries may get additional services. But more importantly, billing under part B gives providers an outlet to another market in which to make sales.

The patients do not pay a copayment for Medicare part A, but they do for part B; so when services are shifted to part B, it does put more of a burden on the beneficiaries.

In 1992, $99 million in patient copays and deductibles were paid for these services under part B. I will give you just one example of where we are seeing that kind of problem exist. In that same year, $44 million was billed to part B for things like surgical dressings and minor medical supplies, things that I think most of us would agree that a nursing home should be providing as its staple product.

The third area I want to talk about is the medical equipment and supplies. We have been spending an inordinate amount of time in this area because of the widespread fraud and abuse that we are uncovering. In the last 4 years, we have had 131 successful prosecutions against unscrupulous providers of medical supplies.

When we begin to see a specific spike up in the cost of individual items, that causes us to stand at attention and take a look at those particular items. I will give you one example of that. We began to see a spike up beginning in 1990 in orthotic body jackets. These are hard covered body jackets that help a person recover from spinal injuries or from muscular problems. In 1990, Medicare paid only $217,000. By 1992, that figure was up to $18 million. We found that 95 percent of the payments there were inappropriate. In fact, we were not paying for orthotic jackets. We were paying for seat cushions and foam covered devices that were keeping people in a chair.

An emerging problem we are seeing is the marketing of medical supplies to nursing home patients. You can take a look at that last chart there that talks about incontinence supplies. These have more than doubled in the last 3 years. It is up to $230 million despite a drop, let me repeat, a drop in the number of beneficiaries using these supplies.

I brought a couple of examples. One of the devices is a female urinary collection device. You can see it here. This device costs $7.38 to the Medicare program. What we were finding was suppliers were billing that but, in fact, delivering this, a common diaper that costs 33 cents. Many of these devices were not needed and clearly Medicare should not have been reimbursing for the diaper when, in fact, the urinary collection device was billed.

Another device that I will bring to your attention is what is called an incontinence kit. This is a kit that helps nursing home staff help clean up a beneficiary who has been soiled. These are not reimbursable by Medicare. Individually, these kits cost $4. What we were finding was that the suppliers were taking the individual items in these kits apart and billing them separately to Medicare costing over $20 per kit. When you add that up to 3 kits per day, 90 kits per month, for each beneficiary, that is an inappropriate billing to Medicare of $1,800 per month. It is these kinds of things that cause us to question about one-half of the costs related to incontinence care and over $100 million that Medicare should not be paying for.

We would like to seek the support of this committee in helping us continue the fight against fraud. With $178 billion at stake, the lure of a fast buck is irresistible to criminals and con artists. Yet at the same time, we are finding ourselves with fewer and fewer resources to fight this battle. We hope the committee will support an initiative that would cause the perpetrators of these frauds to help pay the cost of policing them by establishing a fund at which we would restore the money to the Medicare fund that was lost by fraud and abuse and allow some penalties to be paid to help us increase our efforts. This proposal had widespread bipartisan support in the last Congress. We hope it will have the same support in this Congress.

I will be happy to answer any questions.

[The prepared statement and attachments follow:]

STATEMENT OF MICHAEL F. MANGANO
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning. My name is Michael F. Mangano, and I am the Principal Deputy Inspector General, U.S. Department of Health and Human Services. I am pleased to be here today to discuss issues relating to the Medicare program.

I will focus my testimony this morning on major new initiatives by the OIG, where we are developing recommendations for cost efficiencies. However, I will also catalogue other specific cost saving recommendations that the OIG has made which have not been implemented to date. Finally, I will outline some broader strategies we have established to fight an increasingly complex health care fraud environment and discuss a mechanism we support to finance these new initiatives.

OFFICE OF INSPECTOR GENERAL OVERVIEW

Created in 1976, the OIG is statutorily charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this challenge through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste, and abuse. Our role is to detect and prevent fraud and abuse and ensure that beneficiaries receive high quality, necessary services, at appropriate payment levels.

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress on significant matters. We carry out our mission through a field structure of 8 regions and 65 field offices and with a staff of over 1,200 auditors, evaluators, and investigators.

In Fiscal Year (FY) 1994, we were responsible for 1,169 successful criminal prosecutions and 1,334 administrative sanctions against individuals or entities that defrauded or abused the Department's programs and/or beneficiaries. Last year, the OIG also generated savings, fines, restitutions, penalties, and receivables of over $8 billion. This represents $80 in savings for each Federal dollar invested in our office, or $6.4 million in savings per OIG employee.

THE MEDICARE PROGRAM

The Medicare program is administered by the Health Care Financing Administration (HCFA). Medicare Part A covers hospital and other institutional care for approximately 36 million persons age 65 or older and for certain disabled persons. Fiscal Year (FY) 1995 expenditures for Part A are estimated at $112 billion. Medicare Part B, which covers most of the costs of medically necessary physician and other non-institutional services, has estimated FY 1995 expenditures of $66 billion.

HCFA administers the Medicare program through a contractor system. 43 fiscal intermediaries make payments under Part A and Part B; 34 carriers make payments under Part B; and four specialty contractors make payments for medical equipment and supplies paid under Part B. These contractors operate at 62 sites across the country.

Over the years, HCFA has instituted many significant reforms to the Medicare program to control costs. Payment reforms have included implementation of a prospective payment system (PPS) for inpatient hospital services and a resource based fee schedule for physician services. Administrative reforms have included the regional consolidation of claims processing for durable medical equipment, prosthetics, orthotics and supplies. Medicare administrative costs have been low as a proportion of overall program costs: one percent of Part A claims and 3.5 percent of Part B claims. The implementation of the Medicare Transaction System (MTS) should further streamline claim processing functions.

The HCFA also recognizes the importance of protecting the Medicare program from fraud. A senior official in HCFA, reporting directly to the Administrator, is responsible for coordinating the program's anti-fraud activities. The HCFA has also recently required that Medicare contractors establish fraud units, and we anticipate that these units will increase the number and quality of case referrals to our office.

Nonetheless, as HCFA and we understand, protecting the Medicare trust fund requires continual vigilance. Because of the dollars at stake, the program will always attract unscrupulous actors who attempt to take advantage of loopholes or flout the law altogether in an attempt to enrich themselves at the expense of the taxpayer and the Medicare beneficiary.

Based on our investigative work and ongoing reviews of program costs, we have recently begun major initiatives in several areas where we suspect systematic fraud, waste or abuse: home health, nursing homes and DME. These OIG-wide initiatives have brought the OIG's investigators, auditors and evaluators together as a team, communicating regularly with HCFA officials, to conduct a wholesale examination of these areas. Let me discuss our concerns and activities in each of these areas.

MAJOR OIG INITIATIVES

Home Health

Under its Part A services, Medicare pays for home health services. Among the services beneficiaries may receive under this benefit are: (1) part-time or intermittent skilled nursing care and home health aide services; (2) physical, speech, and occupational therapy; (3) medical equipment and supplies; and (4) medical social services. These services must be provided by a Medicare certified home health agency (HHA).

To receive this benefit, Medicare beneficiaries must be: (1) homebound; (2) in need of care on an intermittent basis; and (3) under the care of a physician with a plan of care established and periodically reviewed by a physician. Once these eligibility criteria are met, the benefit is unlimited as long as the services are considered medically necessary for the treatment of a beneficiary's illness. In addition, beneficiaries are not required to pay any coinsurance or deductibles (except for DME, which requires a 20 percent copayment).

Increasing Costs

Medicare expenditures for home health services have grown dramatically in recent years. In Fiscal Year 1990 the Medicare program spent $3.3 billion on home health. By 1994, four years later, Medicare was spending over $12 billion--a 263 percent increase. These costs are expected to reach $16 billion this year and more than $22 billion by the year 2000, if left uncontrolled--about the same as the entire discretionary budget authority for the Public Health Service in FY 1995.

During this same period, we've seen increases in both the number of beneficiaries using home health services and the average number of visits per beneficiary. The number of beneficiaries receiving home health services has increased 72 percent, from 1.9 million in 1990 to 3.3 million in 1994. Similarly, the average number of visits per person has increased from 36 in 1990 to 65 in 1994, more than an 80 percent increase.

Numerous factors have contributed to the recent growth in home health. The aging of the Medicare population and the development of complex medical technologies that can be provided in the home are two such factors. However, a significant program change in 1988 opened the floodgates for increased expenditures in the home health area. In that year, HCFA issued revised coverage guidelines that liberalized coverage of the home health benefit. The definition of the "part-time or intermittent" requirement was liberalized, and a reinterpretation of the "confined in the home" requirement was expanded to include persons who occasionally leave the home. These changes were largely made to comply with the settlement of a class action lawsuit, which alleged that Medicare contractors were improperly denying home health claims.

Oversight of Home Health

The OIG has observed several types of fraud in HHA operations, including cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff, falsified plans of care, and forged physician signatures and kickbacks. Between 1990 and 1994, OIG investigations led to 25 successful criminal prosecutions of HHAs or their employees and imposed three civil money penalties. In 1993 and 1994 alone, 39 HHAs or their employees were excluded from participating in the Medicare or Medicaid programs.

To respond to concerns about rising costs and program integrity, the HCFA has launched the Medicare Home Health Initiative. The initiative is aimed at assuring the efficient provision of responsive, high-quality, appropriate home health care. It has established six goals: (1) respond to beneficiaries' needs; (2) enhance providers' flexibility in structuring plans of care; (3) ensure provision of high quality care; (4) improve the efficiency of administration and operations; (5) facilitate appropriate utilization of home health services; and (6) ensure appropriate payments for the benefit and enhance efforts to detect fraud and abuse. The HCFA asked that we participate in their effort.

As part of this examination, we are conducting provider-specific audits; validating claims in specific regions of the country to determine the nature and extent of inappropriate payments made under current Medicare rules; and conducting studies to explore how physicians and providers respond to the incentives of the current system, and alternatives to the current program structure and system.

Provider Audits

Through cost reports, HHAs can charge general and administrative costs to the Medicare program. We often find problems in the overhead costs billed to Medicare. For example, one home health agency claimed approximately $14 million in unallowable costs during one cost reporting year, including such expenses as theater tickets, alcoholic beverages, bags of vidalia onions to legislators, and gourmet popcorn in tins for physicians.

Our provider audits also examine the direct costs claimed by the HHA. In some cases, the results have been startling. Consider our findings when we audited a home health agency in Miami Lakes, Florida. Seventy-five percent of the claims submitted by this HHA did not meet Medicare guidelines. Visits were claimed but not made; visits were made to persons who were not considered homebound; visits were made when physicians denied that they authorized them; visits were made to beneficiaries who did not want the service. We estimate that of the $45.4 million claimed by this HHA in 1993, well over half, $25.9 million, did not meet reimbursement requirements. We have just issued a final report on these audit results.

Regional Claims Validation

An ongoing audit in Florida is based on a review of 200 randomly selected claims. This data will help us determine if the kinds of problems we found in Miami Lakes are true of Florida in general. We will provide our findings to the Subcommittee when they are available. Similar efforts are planned in other regions where our investigative work, and leads from HCFA, indicate that specific problems exist.

Incentives and Alternatives

In other ongoing work, we are reporting on the physician's role in home health care. Under the Medicare program, the physician must authorize home health services. The HCFA has recently decided to begin paying physicians for plan oversight. Thus, the extent to which physicians are, or could be, true "gatekeepers" for the Medicare home health benefit warrants our attention and scrutiny.

Our preliminary findings indicate that physicians generally have a relationship with patients for whom they sign plans of care, are involved in making referrals for home care, and review the plans of care they sign. Physicians are most involved with patients with complex medical problems. But they don't make home visits, and they don't directly manage the care the patient receives from the HHA.

We will also issue a final report shortly which provides information about how non-Medicare payers structure and manage their home health benefit. We spoke with 15 other payers including State Medicaid agencies, private insurance companies, health maintenance organizations, the Department of Veterans Affairs and the Civilian Health and Medical Program of the Uniformed Services.

We found that the primary difference between Medicare and other payers is not the benefit packages they offer, but the way they attempt to control home health costs. Other payers are more involved in assessing how their beneficiaries might benefit from home health care, and use case managers to ensure that beneficiaries are properly selected, care is properly provided, and utilization and progress monitored. Unlike Medicare, beneficiaries are assessed copayments and told what the insurer has paid the HHA on their behalf. Other health plans often set limits on the benefit--capping the number of visits that can be made over a specified period, for example.

We believe that HCFA and the Congress might study the merits of some of these approaches as it determines how best to control utilization and costs while assuring the appropriate delivery of high quality care to Medicare beneficiaries.

Nursing Homes

Let me now turn to the issue of nursing homes. Medicare pays for services delivered to beneficiaries in nursing homes under both Part A and Part B of the program.

First, Medicare covers 100 days of extended care services for qualified beneficiaries in a Medicare participating skilled nursing facility (SNF). This benefit was designed to reduce the length of stay in acute care hospitals and transition beneficiaries to their homes or to custodial care facilities. To qualify for the benefit the patient must have spent at least 3 consecutive days in a hospital, and require daily skilled nursing care or skilled rehabilitation services. In 1993, Medicare spent over $5 billion for SNF stays, under Part A of the program.

But Medicare Part B also comes into play, regardless of who pays for the stay in the nursing home itself. In 1992, we estimate that Medicare paid approximately $4 billion for services delivered to residents of nursing homes and billed to the program under Part B. Services that can be billed under Part B for such patients include physician services, laboratory services, radiology services, ambulance, and medical equipment and supplies.

The fragmentation of Medicare payment sources, suppliers and providers raises concerns about cost-shifting; inappropriate payments; overutilization of services; and financial burdens on beneficiaries. I will discuss each of these in turn.

Cost-Shifting

Cost shifting refers to the practice of billing SNF services that are covered under the Medicare Part A extended care benefit to Part B of the program.

The HCFA determines the daily rate it will pay for care in a SNF. This rate is calculated to include multiple services including room and board, nursing care, rehabilitation services, and other routine SNF services. SNFs are given flexibility to determine what services they will provide on a routine basis and bill for under the Medicare Part A cost report. As a result:

- Roughly $57 million in total enteral nutrition charges were allowed in both 1991 and 1992 under Part B when much of those costs should have been billed to Part A. It is clear that under Part A, patients' dietary needs should be covered by the SNF daily rate. Enteral nutrition is a liquid dietary substitute for patients who cannot survive on oral feedings.
- As much as $44 million in 1991 and $55 million in 1992 were charged to Part B for rehabilitation therapy. Rather than the SNF providing the ancillary services and charging them to the Part A program, third party providers billed the therapy as Part B services.
- As much as $44 million in 1992 was paid under Part B for surgical dressings, incontinence supplies, braces, catheters, and similar items.

Savings could result if these items were purchased by the nursing home, acting as a prudent purchaser and taking advantage of discounts, rather than being billed to Part B and reimbursed under fee schedules. We will issue a report shortly on the issue of cost-shifting, and further work on pricing of products under Part A and Part B will help determine the amount of savings possible by eliminating separate payment under Part B.

Inappropriate Payments

Durable medical equipment may only be billed to Part B of the Medicare program if the equipment is provided in the beneficiary's residence. The law specifies that a SNF cannot be considered a residence. Payments totalling $8.9 million in 1991 and $10.8 million in 1992 were made incorrectly for DME in a SNF stay. We have recommended that HCFA correct the system to prevent such payments, and HCFA has agreed.

Overutilization of Services

No single individual or institution is held responsible by Medicare for managing the beneficiary's care while in a nursing home and ensuring that only needed services are delivered to the patient. Indeed, the incentives run in quite the opposite direction. A provider who offers therapy services to residents of nursing homes gains a market for his or her services; the patient may well be happy to receive services of any kind, with any possibility that it might help them medically or socially; and the nursing home's own staff is relieved of caring for the patient during the time the provider is delivering services to the patient.

Likewise, suppliers may deliver unneeded supplies to nursing homes for beneficiaries, but the nursing home has little incentive (except for limited storage space) to turn supplies away. I'll talk about this situation more in a moment.

Financial Burden on Beneficiaries

In 1992, beneficiaries whose stays in SNFs were covered by Medicare paid up to $99 million as their coinsurance and deductibles for therapy, nutrition, and medical supplies and equipment billed under Part B. Had each SNF provided these services under Part A, itself or under arrangement, none of the residents would have been liable for coinsurance or deductibles.

Planned Actions

The HCFA shares our concerns about fragmentation of billing for services delivered to Medicare beneficiaries in nursing homes and is working on possible solutions. With regard to our work on payments to Medicare beneficiaries during covered SNF stays, the HCFA believes that a statutory "rebundling" provision for SNFs, similar to that for hospitals, is needed. Such an approach would also support work to establish a prospective payment system for beneficiaries in SNFs. We agree with this direction, but are also working with HCFA on more short term solutions.

Medical Equipment and Supplies

We continue to focus on medical equipment and supplies, as we have in the past, but in closer partnership with HCFA and the newly established DME regional carriers (DMERCs). Our investigative activity continues to disproportionately fall into this category of service. Between 1990 and 1994, our investigations led to 131 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed 38 civil money penalties. In the last two years alone, we excluded 114 DME companies or their employees from the Medicare and Medicaid programs.

We often take a close, hard look at specific items of equipment or supplies when we see a significant increase in payments over a short period of time. In absence of coverage or coding changes, or new medical information about the proper use and application of technology, such increases have often been an indication of fraud or inappropriate billings.

In the past, using this technique, we have identified problems with seat lift chairs and transcutaneous electrical nerve stimulators (TENS) units, both of which have now been corrected. More recently, we reported on a similar trend with orthotic body jackets--customized, rigid devices intended to hold patients immobile and treat patients with muscular and spinal conditions. Payments for this device went from $217,000 in 1990 to $18 million in 1992. We estimated that 95 percent of those payments were for devices more properly categorized as seat cushions rather than body jackets.

As HCFA has moved to process such claims by specialty carriers, such problems are easier to spot and address. In fact, by the time we issued our findings on orthotic body jackets, payments were already on a downward trend because of this change.

But, there are always new twists. Our recent work suggests that an emerging problem in the medical equipment and supplies area has to do with marketing and targeting of patients in nursing homes. We now find that when unnecessary medical equipment and supplies are provided to Medicare beneficiaries, they are often residents of nursing homes.

An example is our recent work on incontinence supplies.

Incontinence Supplies

Incontinence supplies are supplies used for individuals who have bladder or bowel control problems. The Medicare program covers these supplies when incontinence is of long and indefinite duration. Incontinence supplies include catheters and external collection devices such as pouches or cups. Catheters are flexible, tubular instruments used to control urinary flow. The HCFA will also reimburse for accessories that aid in the effective use of such devices, such as drainage bags, irrigation syringes, sterile saline solutions and lubricants. However, certain items, such as absorbent undergarments or diapers, are specifically excluded from Medicare coverage.

Increases in Costs

Medicare allowances for incontinence supplies more than doubled in three years despite a drop in the number of beneficiaries using these supplies. The amount allowed for incontinence supplies rose from $88 million in 1990 to $230 million in 1993, an increase of $142 million. During the same period, the number of beneficiaries receiving incontinence supplies fell from 312,000 to 293,000, causing the allowance per beneficiary to increase from $282 to $786, a 179 percent increase.

Four types of incontinence supplies account for almost all the increase in Medicare allowances: irrigation syringes, sterile saline irrigation solution, lubricant, and female external urinary collection pouches. These account for 91 percent of the $142 million total increase. Most of these payments were concentrated in one carrier and a small number of suppliers and beneficiaries.

Questionable Payments

Questionable billing practices may account for almost half of incontinence allowances in 1993. Medicare allowed $107 million in 1993 for supplies whose billing is questionable. $88 million was allowed for accessories that were not billed along with a catheter, indicating that coverage guidelines were not met. Another $19 million in allowances were made for beneficiaries who appeared to receive more supplies than necessary.

Supplier Practices

Information from nursing homes indicates that suppliers engage in questionable marketing practices to increase their business in incontinence supplies. Twenty-four percent of nursing homes have reported that supplier representatives decided the number of supplies to be delivered in a given month to beneficiaries. In addition, nursing homes have reported other practices by suppliers such as the routine waiving of beneficiary coinsurance payments as well as offers of inducements in exchange for allowing suppliers to provide incontinence supplies to patients.

Nursing homes have told us that some suppliers present them with false or misleading information. Twenty-two percent of nursing homes received false information from suppliers stating that Medicare is introducing "new broader coverage" for incontinence supplies. One out of ten nursing homes has been misinformed by a supplier that Medicare will cover other routine incontinence supplies such as absorbent undergarments if syringes, sterile solutions, and lubricants are purchased.

We have launched a major national investigation into the marketing and billing of incontinence care kits and supplies to nursing home residents. The potential for great profit provides an incentive for fraudulent marketing and billing schemes which target the entire nursing home population of Medicare beneficiaries. The cost of the supplies contained in an incontinence kit is typically $4. These items are fragmented and upcoded for billing purposes, causing Medicare to be billed about $20 for each kit. Providers usually ship and bill at the rate of 3 kits per day per beneficiary, which is the maximum Medicare will reimburse. At 90 kits per month, the cost to Medicare Part B is $1,800 per month, per patient. It is not surprising that this has turned into a $200 million business.

OTHER COST SAVING IDEAS

Of course, our work and our concerns go beyond the three areas I've just discussed.

Recent Testimony

The Inspector General has recently testified before the Senate on subjects which have cost saving implications. We would like to raise these issues before the new members and new Chair of this Subcommittee as well.

On November 2, 1994, the OIG testified before the Senate Appropriations Committee on oxygen services. At that time, we released a report on services delivered to Medicare beneficiaries receiving oxygen concentrator services. In that study, we found significant variation in the kinds and frequency of services delivered and the frequency of services delivered to Medicare beneficiaries receiving oxygen concentrator therapy. We also discussed our prior work which compared Medicare payments for oxygen to other payers' payments, including the U.S. Department of Veterans Affairs, which pays significantly less than Medicare. At the hearing, the HCFA Administrator committed to a review of payment levels for oxygen concentrators and related services. Medicare allowances for oxygen concentrator rentals in 1993 exceeded $850 million. The subcommittee estimated that HCFA could save over $300 million if Medicare paid the same rates as others.

On December 13, 1994, the Inspector General testified before the same Committee on ambulance payments. Most ambulance benefits are covered under Medicare Part B and have very strict limits. Ambulance transport must be reasonable and medically necessary. No payment may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available. Generally, ambulance transport is covered for patients whose condition requires emergency medical attention, or whose condition makes it impossible to sit and requires transfer by stretcher.

Total Medicare carrier allowances for ambulance transportation under Medicare Part B were $1.52 billion in 1993, on behalf of over three million beneficiaries. Our work on ambulance payments leads us to two conclusions: first, many payments for ambulance transports taking End-Stage Renal Disease beneficiaries to and from dialysis violate Medicare guidelines and should never have been made; second, Medicare has a problem in the way it reimburses for ambulance transports--not just for dialysis patients but all Medicare beneficiaries. As a result, it pays too much. We've estimated that a total of $112 million annually could be saved with various program reforms.

Cost-Saver Handbook

The 1995 edition of the Office of Inspector General "Cost-Saver Handbook," also known as the Red Book, contains a number of options that could also be considered by the Congress to attain greater program efficiency and to enhance the viability of the trust funds. For example, we've made the following recommendations:

Expand the Diagnosis Related Group Payment Window. Separate payments for nonphysician outpatient services are not allowable within 72 hours of the day of an inpatient admission, as those costs are considered part of hospital's payment for inpatient services. For the period November 1990 through December 1991, $83.5 million in admission related nonphysician outpatient services were rendered 4 to 7 days immediately before an inpatient admission, just beyond the current "window." We recommend that the window be expanded in order to encompass more admission related services.

Pay Differently for Admissions not Requiring Overnight Stay. Hospitals are reimbursed when the patient is discharged based on established rates which are based on 494 diagnosis related groups. In 1989, the Medicare program paid for 179,500 admissions which did not require an overnight stay. We've estimated the Medicare program could save up to $210 million per year if covered services related to 1-day admissions without an overnight stay were paid as outpatient services.

Reduce the Indirect Medical Education (IME) Factor. Work by the OIG and others has documented that teaching hospitals have consistently had the highest profit margins under Medicare. Although Congress has previously reduced the rates which give these hospitals add-ons for their teaching costs, the IME factor is greater than is appropriate. Reducing the IME factor would be proper and fair and save the program billions each year.

Change the Graduate Medical Education (GME) Payment Methodology. We have found that Medicare will pay more than its fair share of GME costs if changes in two areas are not made. First, the new payment system allows hospital costs with little or no connection to Medicare to be given increased importance in the calculation of GME reimbursement. Second, the Medicare patient load percentage, used to compute Medicare's share of these costs, does not accurately represent Medicare's share of the cost of services provided to Medicare patients. As a result, we recommended HCFA propose legislative and regulatory changes to the new payment system to more accurately identify Medicare's share of GME costs. These recommended changes to the new methodology will reduce Medicare's share of GME costs by an estimated $157 million a year.

Reduce Hospital Capital Costs. We have determined that historical costs used in setting hospital payment rates were inflated because of excess hospital capacity and the inclusion of inappropriate elements. The newly enacted prospective payment system for capital expenditures is based upon inflated historical costs as part of the formula calculation. Continuing mandated reductions in capital payments beyond FY 1995 (when currently legislated limits expire) would be proper and fair and save the program billions each year.

Change Incentives for Billing Laboratory Services. The Medicare Part B program is paying single test payment rates for chemistry tests commonly performed on automated laboratory equipment. Single test payment rates are paid because HCFA's guidelines regarding chemistry tests subject to paneling have not been updated to add tests as laboratory technology has advanced. Savings to the Medicare program would be about $216 million annually if 10 tests were included as panel tests nationwide. The HCFA has agreed to 8 of those tests.

We also believe that the incentives for billing laboratory services need to be changed. We've put forward two ideas in particular: reinstating of beneficiary coinsurance and deductible provisions for clinical laboratory services as a means of controlling utilization; and rolling in laboratory services as part of the payment for a physician office visit. We estimate over $1 billion in annual savings from the first proposal, and another $1 billion annually from the second, exclusive of the beneficiary coinsurance which would be paid for the office visit.

We don't expect that you'll agree with all the cost saving ideas we've proposed in the Red Book, or even with our savings estimates in all cases. But we believe the proposals in our Red Book are useful for policy makers to consider as they look to contain costs and introduce program efficiencies.

THE NEW FRAUD FIGHTING ENVIRONMENT

I would now like to turn to the broad question of how we can best protect the Medicare program from fraud and abuse. If you asked me what is different today from several years ago in the fraud fighting environment, I would point to three factors in particular–increased sophistication and complexity in fraud schemes; rising Medicare costs, creating a more attractive target for the unscrupulous; and the emergence of new "fraud fighters" to meet the challenge.

I'd like to discuss briefly each of these topics and what I believe are possible solutions to address the challenges before us.

Coordination of Anti-Fraud and Abuse Activities

Now more than ever, there are numerous Federal, State, and local law enforcement groups with a stake in investigating and prosecuting health care fraud. These include the Department of Justice and the Federal Bureau of Investigations; the Inspectors General at HHS, the Department of Defense, the Department of Labor, and the Department of Veterans Affairs; the United States Postal Service, State Medicaid Fraud Control Units and State Attorneys General; and HCFA and Medicare contractor fraud units.

It is essential that we take a leadership role in coordinating the fight against fraud and abuse in the health care marketplace. The Inspector General has taken her leadership responsibilities very seriously and has established this as one of the office's top priorities.

The Inspector General is co-chair of the Executive Level Health Care Fraud Policy Group, which includes representatives of the Attorney General's office, the Civil and Criminal Divisions, and the FBI. The Inspector General also chairs the IG Health Fraud Coordination Council, composed of Inspectors General with responsibilities in health care.

Rising Medicare Costs

Willie Sutton was once asked why he robbed banks. His famous answer was, "Because that's where the money is."

Today's criminals may be more sophisticated, but in one way they remain true to their forebears. They go where the money is.

In 1980, Medicare program costs were $34 billion. In 1990, that number had increased to $107 billion; by 1993, $143 billion; and estimated 1995 costs are $178 billion. With that much money at stake, the lure of a fast buck is irresistible to criminals and con artists.

Investment in the OIG

We see a trend towards increased complexity and sophistication in the various schemes used to defraud the Medicare program, and hence a greater need to call on more investigators, along with attorneys and auditors, to penetrate those schemes. Despite the increased threat, the OIG's resources have declined in the past several years as we have absorbed our share of the Department's budget reductions. This has resulted in a decrease in OIG staff from 1,411 employees in 1991 to 1,207 employees in 1995. By the end of FY 1994, 10 OIG investigative offices in 9 States and Puerto Rico were closed. During the same period, the OIG was required to implement the financial statement audit provisions of the Chief Financial Officer's Act of 1990, other new audit responsibilities, and over 40 new civil monetary and exclusion authorities, without additional funding for those new responsibilities. Our next challenge will be to absorb the loss of 262 staff who will be transferred to the Office of Inspector General at the Social Security Administration.

Funding our activities has been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection--activities that pay for themselves many times over--has actually been curtailed.

Lack of resources to identify waste and combat fraud and abuse is a major problem because it allows harmful practices to continue and defrauders and abusers to escape detection. The limited resources available are inadequate to address sophisticated and complex schemes to defraud and abuse health care programs.

Health Care Fraud Reinvestment Fund

The oversight and enforcement activities of the OIG and HCFA are among the most productive of Federal programs. I mentioned earlier that for every dollar invested in the OIG, we return $80.

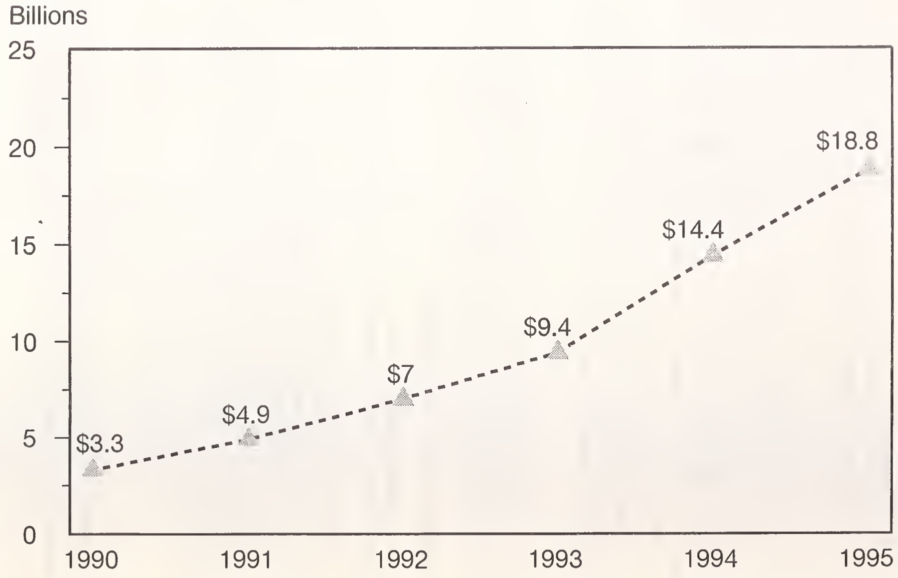
We support a mechanism to increase funding available for combatting health care fraud and abuse without drawing down from the U.S. Treasury, or further burdening taxpayers. Under this concept, certain recoveries generated by our health care anti-fraud activities would be deposited into a reinvestment fund with dollars available to fund additional enforcement activities. Thus, the individuals who actually perpetrate fraud against, or otherwise abuse our nation's health care system, will foot the bill for increasing policing of those programs. Of course, restitution to the Medicare Trust Funds and the affected Medicaid programs would be made before any monies could be deposited into the account. In the last Congress, this concept had wide bipartisan support. I hope, Mr. Chairman, we can win your support for this proposal.

CONCLUSION

Thank you for the opportunity to appear before you today. I look forward to a cooperative relationship with the new subcommittee as the congressional session continues. This completes my written statement. I am happy to respond to any questions you might have.

Home Health

Rapid Growth of Medicare Expenditures



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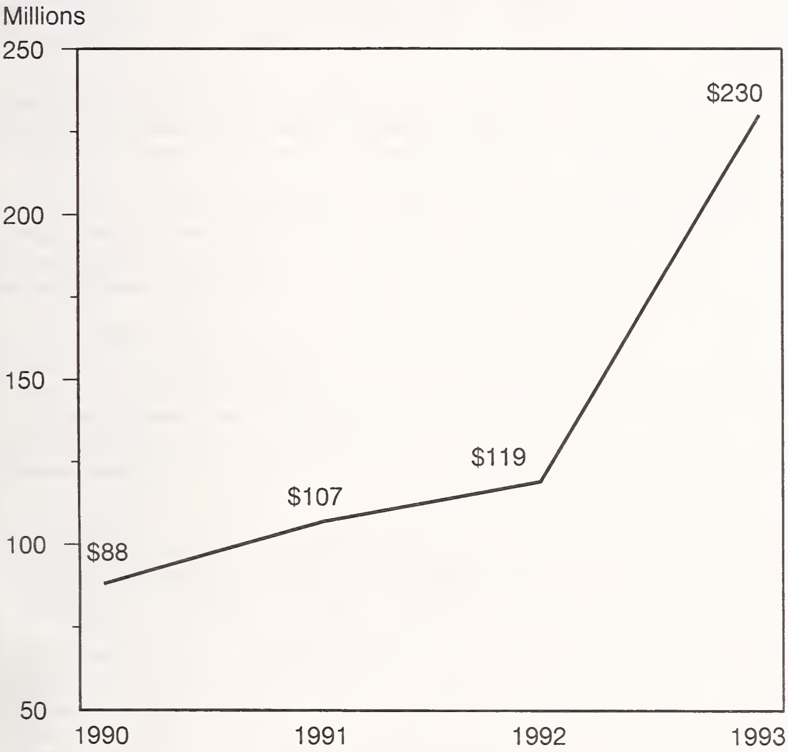
Incontinence Supplies

Payments Have More Than Doubled Over 3 Years



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Chairman THOMAS. Thank you very much for that condensed report. Appreciate it very much.

Mr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, ASSOCIATE DIRECTOR, HEALTH FINANCING AND POLICY, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY EDWIN P. STROPKO, ASSISTANT DIRECTOR, HEALTH FINANCING ISSUES

Mr. SCANLON. Mr. Chairman and members of the subcommittee, we are very pleased to be here today to talk about ways in which the Medicare program could be improved to avoid excessive and unnecessary spending.

I would like now to introduce my colleague, Edwin P. Stropko, who is Assistant Director of Health Financing Issues at the GAO. Today we will be describing how revising certain reimbursement policies and imposing better controls on fraudulent and abusive payments can conserve program dollars.

In short, I will be discussing how loopholes and other weaknesses in reimbursement policies result in the program paying too much for services. Second, I will indicate how weak or absent controls on fraud and abuse result in the program paying for unnecessary services. Finally, I will note some broad administrative initiatives taken recently by HCFA that hold promise to cut Medicare spending for such unnecessary services.

Let me turn to the first area I indicated, problems in reimbursement policy. Our evidence suggests loopholes in payment rules and flawed payment setting methodologies allow Medicare to pay too much for some services. In the near term, immediate savings are possible through modest adjustments of those policies.

For example, in part because of the difficulty of applying Medicare's general rule of paying reasonable costs to specific circumstances, some skilled nursing homes and therapy companies have been able to pad administrative costs and services resulting in Medicare being charged hundreds of dollars per hour for occupational and speech therapy even though therapists' salaries are generally less than $32 per hour. This and other examples illustrate the government's need to act as a prudent purchaser.

However, taking action is not a simple task. HCFA faces strong pressure from those who benefit from high payments often with little countervailing pressure from any specific constituency to make reducing payments a priority.

The second area that I noted which is worthy of attention involves avoidance of paying for unnecessary services due to fraud and abuse. Opportunities exist to cut possibly billions of dollars in spending by implementing better controls over fraudulent and abusive Medicare payments. As you have heard from the Office of Inspector General, Medicare has paid providers' claims for improbably high levels of service or cost.

Additional examples include paying a clinical laboratory $3.1 million in 5 years for mileage charges to transport specimens. Mileage that would allow one to circumnavigate the globe about 230 times or paying a van service $62,000 for transporting a single beneficiary 240 times in 16 months. These abuses came to light because of whistleblowers, not because program safeguard controls detected them.

Medicare pays more claims with less scrutiny today than at any other time in the past 5 years. Administrative funding declines have led to only 5 percent of claims slated for review in 1994. Profiling individual providers' claims to detect questionable billing practices has also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year. This limited investment in oversight occurs despite HCFA estimates that at present levels, incremental spending for antifraud and abuse activities would save $11 in benefits for every $1 invested.

Finally, let me note two broad HCFA administrative initiatives that our work indicates could assist considerably in reducing inappropriate payments. First, the Agency is requiring its contractors not just to examine claims from particular providers that might be overbilling but also to examine claims for specific medical procedures to identify questionable spending patterns and trends within geographic areas.

Second, HCFA is also developing a new claims processing system, the Medicare transaction system, to replace the 11 different systems used by the Medicare contractors who process and pay claims. This system will provide HCFA with improved capacity to reengineer its efforts to manage program dollars and properly oversee contractor spending, savings and workload.

In conclusion, it is clear that Medicare is an expensive program that is growing fast. Despite the urgency of controlling Medicare's high spending growth, however, swift, simple solutions may be difficult to identify and implement.

For the immediate future, HCFA can seek ways with the assistance of the Congress to make the government a more prudent purchaser of health services. By correcting flawed reimbursement policies and making adequate investment in and attention to activities like HCFA's recent antifraud and abuse initiatives, Medicare can avoid making unnecessary payments that can amount to billions of trust fund and tax dollars.

Mr. Chairman and members of the subcommittee, this concludes my statement. We will be happy to answer any questions that you have.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM J. SCANLON
UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the ways in which the Medicare program could be improved to avoid excessive or unnecessary spending. Last fiscal year, federal spending for the Medicare program totaled $162 billion, or over $440 million a day. The Congressional Budget Office estimates that by 2002 Medicare spending could exceed $340 billion. Today we will examine the program's areas of rapid spending growth and ways to conserve program dollars--mainly by revising certain reimbursement policies and better controlling fraudulent and abusive payments. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. I for a list of the issued reports.)

In brief, the government faces strong obstacles to bringing Medicare expenditures under control. Broad-based payment system reforms have slowed aggregate spending, but Medicare's growth rates remain higher than overall inflation. And while additional reforms may be needed, their nature is the subject of much debate. There is less dispute, however, that Medicare pays too much for certain services and supplies. Fiscal pressures have led private and state-government payers increasingly to negotiate discounts with providers and to manage the form and volume of care. Medicare has not exercised its potential market power in similar fashion when buying certain services, such as rehabilitation therapy. Our evidence suggests that, in the near term, the government may want to revise the reimbursement policies for these excessively costly services to ensure that it is acting as a prudent buyer. The evidence also suggests that greater vigilance over wasteful or inappropriate payments could better protect Medicare funds against providers' fraudulent and abusive billings.

BACKGROUND

The Medicare program provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, skilled nursing home, home health, and various other services. About 90 percent of beneficiaries obtain services on a fee-for-services basis, choosing their own physician or other health care provider, with charges sent to the program for payment. Medicare's payments are determined by a complex array of rules and procedures.

Seeking ways to constrain Medicare spending is a daunting task for good reason--the program is typified by paradox. On the surface, Medicare appears to be extensively regulatory, with thousands of pages of laws, regulations, and manuals governing program administration. Yet the individual decisions by millions of beneficiaries and hundreds of thousands of providers determine program spending. On the surface, Medicare is perceived to be a national program that is administered centrally. While on one level this is true, it is also true that commercial insurers--like Aetna, Travelers, and Blue Cross and Blue Shield plans--administer the program locally. By law, HCFA contracts with private insurers to process and pay Medicare claims. Today about 73 contractors perform this function, and each is required to work with its own medical community to set coverage policies and payment controls. Despite its image as a national program, therefore, Medicare's terms for covering medical care depend on each contractor, except in the few instances where HCFA has established national policies.

As intended, the contractor network has kept Medicare's policies within close reach of local provider communities. When HCFA issues guidelines and regulations, it does so only after extensive comment by the relevant segment of the health care industry. The program was designed this way to protect against undue government intervention in the nation's health care. As a consequence, however, HCFA faces obstacles in making the government a prudent buyer of health care services.

CONTROLLING MEDICARE SPENDING IS CHALLENGING

Competing pressures challenge the government's ability to control Medicare spending. The multiple stakeholders involved and the potential market impact of enacting Medicare cost containment reforms argue for proceeding cautiously, while growing budget deficits call for immediate corrective measures.

In the last decade, the Congress has enacted two major legislative reforms that have slowed Medicare spending. A prospective payment system (PPS) using diagnosis-related groups helped bring aggregate spending growth for inpatient hospital services from about 15 percent in the early 1980s to about 8 percent a year today. A fee schedule known as RBRVS (resource-based relative value scale) and limits on spending increases known as volume performance standards helped reduce aggregate physician payment growth from over 10 percent in the late 1980s to 2 to 5 percent over the last few years.

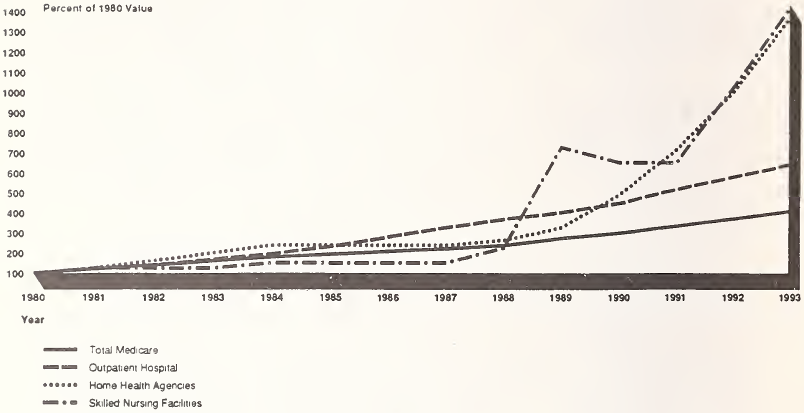
Still, Medicare spending growth remains at high levels for two reasons. First, the inpatient hospital and physician spending categories amount to $112 billion--over 75 percent of total Medicare spending. Despite some moderation, growth in hospital payments, after accounting for the growth in beneficiary numbers, still exceeds the growth of the nation's economy as measured by the gross domestic product. The sheer size of these spending areas means that each percentage point of growth represents hundreds of millions of dollars and helps account for the projected more-than-doubling of spending to $340 billion in 2002. (See table 1.)

Table 1: Medicare Payments and Growth Rates for Selected Service Categories

	Year	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Total Medicare	Payments	36.4	43.6	51.1	58.1	65.1	70.3	75.8	80.5	86.8	99.4	109.2	121.2	134.6	149
	% Increase		20%	17%	14%	12%	8%	8%	6%	8%	15%	10%	11%	11%	11%
Inpatient	Payments	24.5	29.4	33.9	37.8	42.3	44.9	46.5	47.1	49.1	55.5	59.8	65.7	72.5	78.1
	% Increase		20%	15%	12%	12%	6%	4%	1%	4%	13%	8%	10%	10%	8%
Physician	Payments	8.4	10.1	12.1	14.2	15.7	17.2	19.6	22.2	24.5	26.8	29.5	31.6	32.3	34
	% Increase		20%	20%	17%	11%	10%	14%	13%	10%	9%	10%	7%	2%	5%

Second, spending growth for other categories--such as outpatient hospital, home health, and skilled nursing care services--has accelerated dramatically. Between 1992 and 1993, spending for outpatient services grew by 11 percent to about $12 billion, and spending for home health and skilled nursing care each grew by about 40 percent to $11 billion and $5.7 billion, respectively. Ironically, this growth stemmed in part from the cost containment success of PPS, which prompted providers to shift the delivery of such procedures as cataract surgeries to outpatient settings. In addition, reduced hospital stays may have increased the demand for services provided by home health agencies and skilled nursing homes. (See fig. 1.)

Figure 1: Growth in Medicare Payments and Fastest Growing Services



Home health and nursing home spending, the program's fastest growing components, have expanded also as the result of external pressure to interpret Medicare's coverage rules for these services more liberally. This pressure, in the form of successful legal actions against the program, was precipitated by Medicare's attempts following the introduction of PPS to scrutinize the appropriateness of home health and skilled nursing home claims. Over the past decade, HCFA has been exploring ways to pay for these services prospectively, both to control prices of services and create incentives for appropriate utilization. However, sweeping changes to payment and coverage policies for major services like home health raise complex issues that may be difficult to resolve quickly.

LOOPHOLES AND OTHER WEAKNESSES PERVADE CERTAIN REIMBURSEMENT POLICIES

Immediate savings in the billions of dollars are possible, though, by modest adjustments to certain reimbursement policies. Loopholes in payment rules and flawed rate-setting methodologies allow Medicare to pay too much, in certain cases, for rehabilitation therapy, magnetic resonance imaging (MRI), and anesthesia services. Consider the following cases:

-- Skilled nursing homes and therapy companies have been able to pad administrative costs and inflate charges because of lax oversight of providers' cost reports and the resources needed to apply Medicare's general rules to specific circumstances. As a result, for some beneficiaries, Medicare has been charged the equivalent of hundreds of dollars per hour for occupational and speech therapy, though therapists' salaries are generally less than $32 per hour.

-- Medicare does not systematically lower payment rates for new technology services as they mature and become more widely used and as providers' costs per service decline. For example, Medicare payments for MRIs supported a proliferation of MRI machines in Florida, where payment rates were so high that even inefficient, low utilization providers could earn profits.

-- Anesthesia payments, unlike payments to other physicians, are based on units of time, thus providing a financial incentive to prolong anesthesia service delivery. Our studies have shown that reported times for the same anesthesia service vary widely for no apparent reason and that basing fees on a procedure's median anesthesia time could reduce Medicare payments by over $50 million a year.

Together these problems illustrate the government's need to act as a prudent purchaser. In each of these cases, Medicare has continued to pay higher rates than necessary in a competitive health care environment. Yet taking action is not a simple task. HCFA faces strong pressure from those who benefit from high payments, often with little countervailing pressure from any specific constituency to make reducing payments a priority.

For example, despite projected savings, HCFA has been unsuccessful in its attempts to change its method of reimbursing for anesthesia services. Similarly, since 1993 HCFA has been exploring ways to address the inappropriate billing and payment of rehabilitation therapy claims, while spending for these services is growing at nearly 30 percent a year. Finally, HCFA has taken some action to lower spending for MRIs and other expensive technology, but not before its initially generous reimbursements allowed an oversupply of certain technology to drive up overall health care spending. HCFA still needs to develop methods for reimbursing the capital costs of new technology based on the lower operating costs achievable through efficient utilization.

CONTROLS OVER FRAUD AND ABUSE OFTEN WEAK OR ABSENT

Other opportunities to cut possibly billions of dollars in spending involve implementing better controls over fraudulent and abusive Medicare payments. Over 98 percent of Medicare spending is for payments to providers. Program administration--claims processing and activities to prevent inappropriate payments--constitutes slightly more than 1 percent of total Medicare spending. Less than one-quarter of a percent goes toward checking for erroneous or unnecessary payments.

Controls over waste, fraud, and abuse help ensure that Medicare does not pay for unnecessary or inappropriate services. Some controls are electronic and are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. They also suspend payments for such clerical errors as the incomplete or erroneous number of digits in a provider's billing number. The computer automatically holds the claim until the data are corrected. Medicare's electronic controls are developed and applied largely at the discretion of Medicare's claims processing contractors.

The best way to understand what better Medicare payment controls might accomplish is to examine what has occurred in their absence. In some instances, Medicare has paid providers' claims for improbably high levels of service or cost. For example, the following are abuses that have come to light through whistleblowers, not because program safeguard controls detected them:

-- Over 5 years, Medicare paid $3.1 million in mileage charges to a clinical laboratory for transporting specimens. This amount reflects a distance of 5.7 million miles, equivalent to circumnavigating the earth about 230 times.

-- Over 16 months, a van service billed Medicare $62,000 for ambulance trips to transport one beneficiary 240 times.

In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier. Yet Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Funding declines, relative to the growing number of Medicare claims, have forced HCFA to lower the proportion of claims that contractors must review. In 1989, HCFA set targets for contractors to suspend processing and then review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994.

Similarly, HCFA's efforts to statistically profile claims that detect providers' questionable billing practices have also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year.

In some instances, for lack of adequate funding, contractors have curtailed or discontinued reviews of certain medical services, even when there was evidence of widespread billing abuse and potential for significant savings. For example, a contractor we visited last year temporarily reduced or suspended the use of five electronic controls that triggered further claims reviews. These reviews had previously resulted in the denial of claims submitted and $4 million in savings over a 3-month period. The contractor suspended the use of the controls because the volume of claims they generated overwhelmed the claims review staff.

The decline in program spending for fraud and abuse controls corresponds in part with the 1990 passage of the Budget Enforcement Act. That act places stringent limits, or caps, on discretionary spending, which covers Medicare administrative costs, including the cost of contractors' fraud and abuse controls. Benefit payments, however, are not subject to these caps. This creates a dual problem. Any increase in spending for Medicare's fraud and abuse controls would require cuts in funding for other discretionary programs, such as education or welfare. A decline in benefit costs, however, even if attributable to savings from fraud and abuse activities, cannot be used as an offset. In fact, funding for fraud and abuse activities is in continual jeopardy, since cutting this funding frees up money for other discretionary programs.

HCFA studies indicate that spending for antifraud and abuse activities can reduce Medicare program costs on average by as much as 11 times the amount invested. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity to control Medicare program costs.

HCFA'S BROAD ADMINISTRATIVE INITIATIVES COULD CUT MEDICARE SPENDING CONSIDERABLY

HCFA has begun two major initiatives to address long-standing problems with inappropriate payments. First, it established a data analysis requirement, called focused medical review, for contractors to better identify excessive spending. Second, HCFA let a contract to design a single automated claims processing system--called the Medicare Transaction System--that promises greater efficiency and effectiveness in claims processing.

Prior to the focused medical review requirement, contractors were expected to examine claims looking only for physicians and other providers whose claims suggested they might be overbilling or engaged in some other wrongdoing. Under the new requirement, contractors must also examine spending for medical procedures to identify questionable spending patterns and trends.

For example, when a Medicare contractor in Tennessee compared its payments for selected services with those of other contractors, it found an instance where total payments for a service--pathology consultations--were not in line with other contractors' totals. Specifically, the contractor was paying pathologists for consultations when the test results should have been interpreted by the requesting physician. The contractor revised its payment rule governing pathology consultations, and reimbursements for this service declined from $2.7 million in 1988 to less than $11,000 in 1992.

HCFA's development of a new claims processing system--MTS--is intended to replace the 11 different claims processing systems used by Medicare contractors with a single system expected to have improved capabilities. This system will serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. Using the current multiple systems, HCFA has difficulty aggregating information on spending, savings, and workload at the various claims processing contractors. Inadequate management information makes it difficult for HCFA to provide the oversight required of a national program. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. Full implementation is at least 3 years away. In 1994, we recommended continued top management and congressional oversight to ensure the system's success.

CONCLUSIONS

Medicare is an expensive program that is growing fast. Because of its vast size and the aging of the population, broad-based reforms will be required to keep Medicare from consuming ever-larger shares of the national income. Despite the urgency of controlling Medicare's high spending growth, however, the program's complexities militate against swift, simple solutions. Reforms have moderated spending growth for inpatient hospital and aggregate physician services, but the lower growth still increases Medicare spending in multibillion dollar increments. Moreover, for the program's fastest-growing spending components, such as home health services, the government faces significant challenges to implementing major cost containment reforms.

For the immediate future, HCFA could seek ways, with the assistance of the Congress, to make the government a more prudent purchaser of health services. By correcting flawed reimbursement policies, such as those for rehabilitation therapy, high-cost technology, and anesthesia, Medicare could lower its spending growth rate. In addition, with adequate investment and attention to activities like HCFA's recent antifraud and abuse initiatives, Medicare could avoid making unnecessary payments that could amount to billions of trust fund and tax dollars.

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Mr. Chairman and Members of the Subcommittee, this concludes my statement. We will be happy to answer any questions.

RELATED GAO PRODUCTS

Medicare Part B: Regional Variations and Denial Rates for Medical Necessity (GAO/PEMD-95-10, Dec. 19, 1994).

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994).

Medicare: Technology Assessment and Medical Coverage Decisions (GAO/HEHS-94-195FS, July 20, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GA0/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Psychiatric Fraud And Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 1993).

High-Risk Series: Medicare Claims (GAO/HRD-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992) and related testimony (GAO/T-HRD-92-29, May 7, 1992).

Medicare: Variation in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991).

Medicare: Need for Consistent National Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 13, 1991).

Chairman THOMAS. Thank you very much, Mr. Scanlon.

Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Mangano, I appreciate your testimony because now I know who to call when constituents call me and say that they have got this $90 device in front of them that they know they can make for $20. And I am going to add to your show-and-tell list there.

Mr. MANGANO. OK.

Mr. CHRISTENSEN. You said that HCFA does not have adequate mechanisms for determining which services should be paid by part A or part B.

Can you estimate to what degree HCFA has lost control over the program and how much we are spending as a result of its inability to effectively manage the program?

Mr. MANGANO. It would really be hard to assess how much money is being spent that shouldn't be spent because we only find it when we do find it in our individual studies. In one study that we just completed for Medicare part B, durable medical equipment, as an example, can only be billed in the home. It cannot be billed for a patient that is in a nursing home.

We found about $11 million that was being billed under durable medical equipment in a nursing home under part B services. On the face of it, that should not have been reimbursed. The big problem that occurs in a nursing home is that a nursing home gets to negotiate a little bit about what services they will provide; so when they are getting their part A payment, they can say that Medicare will not cover other kinds of things that you and I would think should have been covered.

In addition to things like medical supplies, about $55 million in 1993 was charged to the Medicare part B program for rehabilitation services. Over $40 million was charged for epidermal nutrition programs. These are nutrition programs where a person cannot eat like you or I but have to take their nutrients intravenously. There are any number of areas where these things are occurring.

We spot them when we see these big spikes start to go up in the reimbursement area. It is very difficult to determine how much actually is being spent out there that should not be spent.

Mr. CHRISTENSEN. At the end of your testimony, you spoke about the Medicare fund and about monitoring it better and having the money go toward that. As a new member on this committee, I am not aware of what you did in the 103d Congress. What suggestions do you have to improve on what we did in the 103d?

Mr. MANGANO. Sure. In any number of bills that had wide bipartisan support, there were suggestions for things called health care fraud and abuse control which basically said that when we investigate fraud and abuse and we have a successful prosecution, the program ought to be restored every penny that it lost because of that fraudulent activity. We would do that first. In addition to that, judges often require that penalties and fines be charged.

They also sometimes award investigative costs for what it cost the government to investigate the individual incident. What we are suggesting is that in the area of fines, penalties, and investigative costs, that a portion of that be put aside to help the Inspector General's Office and the Health Care Financing Administration increase our activity in the fraud and abuse areas. In this way, the perpetrators of fraud will be actually paying for the increased policing, not the taxpayers.

We quite well understand the burdens that you are under in the Congress of not wanting to exceed the discretionary budget caps. The budget in the Inspector General's Office is included under the discretionary accounts so we are very much aware of that. What we are looking for is a funding mechanism by which you would not have to increase the cost to the taxpayer.

We are very proud of the fact that we return about $80 to the taxpayers for every $1 invested in the Inspector General's budget. We would like to help increase that return on investment by having more money to work with to bring more money back.

Mr. CHRISTENSEN. In closing, it sounds like you are doing a good job and I know that we want to do whatever we can to help you in your efforts. But I am always concerned by government agencies that police and monitor everything in the private sector. For example, other organizations, namely the EPA, have been nothing more than huge bureaucracies as far as their fining and overpolicing of the private sector.

What suggestions would you have for us to monitor better through private sector solutions? Any ideas?

Mr. MANGANO. Let me mention that there are a lot of checks and balances against our being abusive in policing the system. The system is replete with checks and balances. We cannot have a successful prosecution unless a U.S. attorney decides the case is worthy of carrying forward. We can't have a successful prosecution unless a judge or a jury awards damages, et cetera.

With regard to the private sector, we helped start about 10 years ago an organization called the National Health Care Anti-Fraud Association. It is an association of large insurance companies that have banded together in this association to begin their assault on fraud and abuse.

We have been working with that organization for the last 10 years and in fact hold a seat on its board. We have training sessions once a year to help them understand the kinds of schemes that we are finding in the government that they can then pick up on and look at in their own insurance companies. Occasionally they tell us of things that they are finding that we could follow up.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from New York, Mr. Houghton.

Mr. HOUGHTON. Thank you very much, Mr. Chairman.

Thank you gentlemen for being here. Your testimony was extraordinarily interesting, as this whole thing is. I have got to say that the study and understanding of our health system is the single most complex issue I have tried to ever wrap my arms around, so I appreciate your particular illustrations here.

I guess I want to ask a broad question here. You both have said, you said, Mr. Mangano, that Congress has got to study the merits of a variety of different approaches and I think Mr. Scanlon you said the same thing. There are specific things that can be done, but you suggested about correcting fraud reimbursement policies, we really ought to get into the larger picture.

I guess the question I have got is this. I don't know whether we are trying to work a system that has just gotten too big. I don't know how you feel about this. You argue the programs and complexities preclude swift, simple solutions. But are you really saying that this means we should have an entirely different approach?

And let me just add one other thought here. That the bigger the system, the more micromanaging is necessary. So is there a way to flip it so that the individuals are monitoring the systems the way they do in other parts of life, or do we have to continue managing an ever-increasing huge bureaucracy which is called Medicare?

Mr. SCANLON. I think I share your frustration about trying to come to grips with the health care system and I think part of it is the same kind of frustration that individual consumers face in trying to assess what types of health services they need. Basically, we all suffer from an information problem. We don't know what services are really required for our best interest and, therefore, we need to rely on providers, creating an essential conflict of interest.

This problem is being addressed by the private sector. As the previous panel indicated, the private sector is well ahead of the curve in terms of trying to create a set of incentives for both providers and consumers that encourage the delivery of appropriate care. Medicare is a huge program and there have been a number of proposals to reform it that have talked about still giving people maximum choice, including remaining in the traditional program. Our concern is that while taking advantage of the private sector initiatives is essential for Medicare to consider, there is still a need to worry about the management of what remains in the traditional program. And that is a daunting task given the complexity and the size of this activity.

I think the private sector is also not ready to suggest that they have a simple or single solution to insure only appropriate care is delivered, but that they are trying a variety of alternatives. One of the private sector's advantages is that it is able to move much more quickly in terms of changing its system than can a public program.

Mr. HOUGHTON. Would you like to answer, Mr. Mangano?

Mr. MANGANO. I would just like to add we share your concern. This is a massive system. When I talked about $178 billion in Medicare, that was only the Federal money and not the beneficiaries' portion of it. That doesn't even take into effect the Medicaid system, which is another $92 billion Federal money and then States share after that.

I think you have to work a system that is that large from many different factors, many different facets. One of the best ways we get good leads for investigations is when beneficiaries get a notice in the mail from their insurance company saying that Medicare paid *x* amount for these following services and the beneficiary will say, wait a minute, I didn't get that kind of service and they will call our office and tell us about it.

I think some of the approaches through managed care have a lot of promise. Right now I believe Medicare has about 8 to 10 percent of its beneficiaries in managed care. Managed care presents a different kind of problem.

In the fee-for-service system, we are worried about beneficiaries getting unnecessary services. In managed care, we have to be concerned about some, and granted it would be very few, providers who would provide too few services to increase their profits.

What we can do is automate the system as much as possible to identify where the aberrancies show up. When we see these rocket ship charts where, all of a sudden, for 1 or 2 years costs go up dramatically, we know something's happening in the marketplace. We have to jump in and take a look at it. Medicare has taken a number of initiatives which do take advantage of some of that technology.

Mr. HOUGHTON. I guess the worry I have, I have only got a little time left, is there is such a huge discrepancy between those who pay and those who receive and there are so many inner layers that you said in your testimony, Mr. Scanlon, that the government has tried to take a couple of cuts at this. One was in this PPS, prospective payment system, and the other was in terms of this resource-based relative value scale.

I don't know how many people out there in the United States really understand what that is. But what we are trying to do is to constantly take a cut at a system which is really imperfect and it doesn't give the people who receive an incentive to save money because they don't know how to do it.

Mr. SCANLON. I think that is the case. We have not found the solution as the previous panel indicated. Almost all Medicare beneficiaries have some form of secondary payment that removes the incentive that program designers attempted to create through coinsurance to make people more sensitive to the cost of services.

The resource-based relative value scale and the prospective payment system have had their impact in changing provider behavior, though. As the panel indicated, there are other areas within those two broad systems where things could be improved and what we have tried to identify today are other areas that also are in need of improvement.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Thank you, gentlemen.

Chairman THOMAS. Thank you.

Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Mangano, I have always been of the opinion that home health care in the long run will save dollars versus nursing or hospital care. Now, my question is: If in fact we can root out the payment for nonvisits and some of the other abuses, is that statement not still correct?

Mr. MANGANO. I believe there is great promise in home health care services because it does eliminate the need to have persons go to nursing homes, which is the most expensive care that we can be providing in this country. So if we can ratchet down some of these abuses in the system, I think we also need to be thinking about mechanisms to avoid some of the most prevalent abuses.

In addition to services that are not wanted, you can get into the problem of having services that are beyond what is needed in a case. A physician has to fill out a form that would allow a person to receive home health care services, but that physician usually does not follow the patient after they have completed that evaluation. They don't make house visits, and they don't look at the managed care.

We have been looking at a variety of other systems used by other payers, like the Veterans' Administration, the CHAMPUS program, Civilian Health and Medical Program of the Uniformed Services, HMOs in which they establish a case manager. That case manager would decide whether the person really appropriately needs those benefits. They will follow the utilization and the progress of the beneficiary. They will also cap the number of visits, and they will require a copayment.

Mr. KLECZKA. We have a project program going on, a 3-year project program in Milwaukee called "I-care" which is doing exactly that.

Mr. MANGANO. Right.

Mr. KLECZKA. During this period, have we seen any reduction in cost for part A or the nursing home?

Mr. MANGANO. Absolutely not.

Mr. KLECZKA. Why? Because utilization has increased? Or is it hard to say?

Mr. MANGANO. In the home health area, the number of visits has doubled in the last 4 years. The nursing home costs have also been going up steadily for the last 4 years. The home health benefit has all of a sudden skyrocketed.

We can claim that there are technologies that can be carried out in the home so that people don't have to go to a nursing home. The numbers of people added to the aged population are also increasing.

Mr. KLECZKA. That is why you can't track cost savings because you are not tracking that one piece.

Mr. MANGANO. That is correct.

Mr. KLECZKA. You might track a bunch in health care, all of a sudden 30 more go into nursing homes. You indicated in your statement skilled nursing facilities are billing under part B where they should be covered under part A. We have intermediaries who are charged the responsibility of reimbursing those providers. Why don't they buck those claims?

Mr. MANGANO. They have trouble matching the person with the two different billings. The Medicare program will receive a billing for part A services for a person in a nursing home. The part B is really a separate process. They have to have a process where they begin to match these. In doing this study, we had to physically do matches between the two programs so we could track the individual beneficiary.

Mr. KLECZKA. But you would think that once they pull up Joe Smith on the screen, and the code is nursing home patient, B should not be applicable for reimbursement.

Mr. MANGANO. Right. That is correct. And clearly Medicare needs to do a better job in that area.

Mr. KLECZKA. The next question is relative to the example you have with the cleanup devices where a packet is $4, but the split up, it is $20. Is there any additional financial incentive to the nursing home to buy the $20 split package versus the $4? What is their cut? What is their benefit?

Mr. MANGANO. We found some real interesting things when we did that. We found nursing homes getting boxes and boxes of supplies of these kits. The medical equipment supplier was charging them off to the individual beneficiary and sending its bill directly to Medicare so the nursing home never saw the bill.

So there is an advantage to the nursing home in that they have this large supply of medical devices and supplies that they can use on an everyday basis for all the beneficiaries in the home. These are things we think would have been the normal responsibility of the nursing home itself.

Mr. KLECZKA. OK, but what is in it for the nursing home?

Mr. MANGANO. Free supplies.

Mr. KLECZKA. They get free supplies, so that saves them overhead costs and equipment costs.

Mr. MANGANO. That is correct.

Mr. KLECZKA. The supplier is the one making all the money from that transaction?

Mr. MANGANO. That is correct.

Mr. KLECZKA. Mr. Chairman, let me go on to one further question. A letter I received from a constituent who writes to me he has power of attorney for his mother-in-law. She has Alzheimer's and recently became incontinent. They were told, or the family was told by the residence where the mother-in-law stayed, that the devices for the incontinence would cost somewhere around $2 apiece. So the residents went out and purchased these from a company in Florida, Tampa, Fla., called Meditech. And the end result was that instead of $2 per item for the incontinent diaper, they were billed for the urinary collection devices, some $1100, which translates to over $10,000 on average per year. And the constituent talks about Depends. Are you aware of, and I guess there might be many kinds, are you aware of what is a urinary collection device and how does that differentiate from a Depends?

Chairman THOMAS. I tell the gentleman, just earlier, we had a show and tell and we have got to repeat the show and tell?

Mr. KLECZKA. No, no.

Chairman THOMAS. This has an impact and you need to see it.

Mr. KLECZKA. I was here.

Chairman THOMAS. That is it.

Mr. MANGANO. This is one of the devices, the female urinary collection device which Medicare is billed $7.38, as opposed to the 33 cents for the diaper.

Mr. KLECZKA. That could be the urinary device.

Mr. MANGANO. That could be it.

Mr. KLECZKA. Originally the resident said it would cost $2 and they were talking something similar to a Depends.

Mr. MANGANO. Yes. Depending on what the device was itself. An individual diaper, we can buy for 33 cents. But depending on what the specific needs of the individual was, that device may be something more elaborate than that.

Mr. KLECZKA. But the individual indicates that the only difference in his—and he is not a medical expert, is that the Depends are not wrapped separately. The device that they are paying for, that we are paying $10 for, is wrapped separately. So evidently there must be a comparison with diaper, the diaper versus the device you showed us before.

Mr. MANGANO. Or it could be what we call fragmenting the billing where they take a package which has maybe three or four items in it, separate them and bill separately for each of those particular items so the cost when you are billing separately is much, much higher than billing for the one individual package.

Mr. KLECZKA. Evidently there were two shipments, one for 27 and one for 25, so there is some bulk there.

One last question since I have a little time left, Mr. Chairman, or I can come back in the second round?

Chairman THOMAS. If you have got one last one, go ahead.

Mr. KLECZKA. For a product like this, does a doctor issue an order?

Mr. MANGANO. No.

Mr. KLECZKA. Or can a home go out and get it?

Mr. MANGANO. A home can order it for the patient.

Mr. KLECZKA. It is their decision whether the patient should have a Depend or an individually wrapped device?

Mr. MANGANO. That is correct.

Mr. KLECZKA. Why wouldn't they go local purchase versus running to Meditech in Tampa, Fla.?

Mr. MANGANO. There are any number of reasons.

Mr. KLECZKA. There are a lot of pharmacies where they can be purchased.

Mr. MANGANO. What we found is a very aggressive marketing strategy on the part of medical suppliers to go to the nursing homes and say Medicare has an expanded benefit for this particular type of service. They say, "If you order from us, we would take care of all the needs of your nursing home. You don't have to go and deal with a lot of other providers."

The nursing homes will say, "Are you sure that Medicare covers this"? "Absolutely, and you won't have to bill for it yourself. We are going to bill for it through Medicare part B."

Mr. KLECZKA. Who gets the color TV at Christmas? I am sorry.

Chairman THOMAS. The gentleman's time has expired.

Mr. Johnson of Texas.

Mr. JOHNSON OF TEXAS. Thank you. Appreciate you bringing that issue up.

I, you know, agree with an earlier questioner that looks like to me you guys are getting into micromanaging the system. And even though you claim you make a lot of savings, which I have heard many times in Texas from our own comptroller, give us more people, we will return you more money, somewhere there is a point of diminishing returns or no returns.

Can you tell me what level of additional resources you think you need to maximize your activities and why?

Mr. MANGANO. We are not even close to seeing the bottom of this barrel. We will get a minimum of 2,000 to 3,000 allegations a year. We can't really work but about one-third of those. We will pass them on to other law enforcement organizations in hope that they can cover it.

As the health care dollar has increased——

Mr. JOHNSON OF TEXAS. Well, when it becomes a matter of law or a violation of law, why shouldn't the criminal or investigative processes do this?

Mr. MANGANO. The FBI has authority to do it but they are busy on a lot of other things as well. There are State Medicaid fraud control units.

Mr. JOHNSON OF TEXAS. What you are telling me is you need to be a separate police unit or a separate investigative unit, the ones that are set up to do that work, which are authorized by law to do that work, you are going to usurp their power.

Mr. MANGANO. The Inspector General Act of 1978, which dealt with the Inspectors General, required the Inspectors General to have two basic functions. The first was to audit the programs of our department and the second was to carry out investigations of fraud and abuse against the programs of our department. So we have been doing this for a number of years.

Mr. JOHNSON OF TEXAS. I don't have a problem with that. But you also say that you are going to do studies and provide information about how non-Medicare payer structures manage their home health benefits. It sounds like that is a process that ought to be left to the private sector and not to an IG.

Mr. MANGANO. The kind of studies we do are meant to look at the programs of our department and see where the vulnerabilities are so we can follow up with specific audits or specific investigations. Occasionally we will look to the private sector where we think there is something to be learned about how the Federal Government can do its job better.

For home health services, we took a look at the private sector to see how some of the managed care companies are doing. We think this information can be useful to the Medicare program as well.

Mr. SCANLON. In addition to fraud activities, there is the question of abuse. Not necessarily intentional abuse, but providers unwittingly or unknowingly providing services that the program does not want to pay for. There isn't, in our view, adequate attention to those kinds of occurrences because contractors' budgets, in addition to the Inspector General's budget, have declined over the years relative to the volume of claims that are coming in to be processed. A greater investment in oversight would now seem to be able to generate savings.

But we would agree with you that it is not an unlimited investment that is called for but a carefully monitored investment to see what the returns are in savings. Additional investments should stop as soon as those returns decline to a point where the investments are no longer justified.

Mr. JOHNSON OF TEXAS. OK. And Mr. Mangano, though, is it true or false that you are duplicating some of HCFA's audit processes?

Mr. MANGANO. No, absolutely not. As a matter of fact, at the beginning of the year and many times throughout the year, we will sit down with HCFA to go over the kinds of activities that they are going to be carrying out that year. We work very closely with them to make sure we don't duplicate each other. Neither one of us has a dollar to spare in this activity so we are trying to make it go as far as we can.

Mr. JOHNSON OF TEXAS. Would it be more economical to have it all in one agency, yours instead of the Health Care Financing Administration? Why do they have one?

Mr. MANGANO. There are a number of activities that they carry out that I would consider program management activities. When you cross the line into auditing activities and investigation, you are moving into the Inspector General's area, but there are some activities that sort of look in the middle, in the gray area; and that is where we want to make sure we don't duplicate each other.

Mr. JOHNSON OF TEXAS. Well, I would agree with that. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson.

If anybody is watching this either live or some time in the future, I am sometimes really concerned that folks who aren't in this room think we are as dumb as we appear to be and I want to assure anyone within my voice or picture that we are not. When you set up a fee-for-service program and it is a catch-me-if-you-can operation and there are people out there who are willing to be not just unethical but criminal in their behavior, the report that you have given us would clearly occur.

When you add billions of dollars to that mix, this report, although sad, probably shouldn't be unexpected. If you pay someone money to dismantle a package and you are dumb enough to pay them for the specifics in the package, which total greater than the package itself, someone will do that.

So as we listen to your testimony, it is neither all that enlightening or significant to me except to say that we have been dumb for a long time. But it is just not us. The system was dumb for a long time. And there are ways to learn from what is going on in the private sector to correct our problems.

Isn't it reasonable to say that if you capitated the payments in a general area for services, that crooks would tend to get out of the business because they don't have this multiplier or additive procedure which is of no problem to them but that if it was a capitated system and they had to deliver services under a structure in which all of the dollars didn't matter, just the final service did, that we could go after this problem to a certain extent?

Isn't that true? Either one.

Mr. SCANLON. I think we find that the problems that we have been noting today are in areas where there is no form of capitation. As Dr. Altman pointed out, the Medicare prospective payment system in some ways capitates the admission to a hospital. We are finding that areas where we allow the breakdown of services into their individual components and separate billing are where the problems occur.

The challenge in correcting those situations is to define what is going to be the unit of service that we are going to capitate. Global capitation, such as moving into managed care with HMOs, is one alternative. The HMOs then face the challenge of dealing with their providers to define units. To the extent that we maintain a fee-for-service system in Medicare, we will have to develop alternative capitation units to better manage service provision.

Chairman THOMAS. At least with the managed care, you have turned folks in on themselves in terms of making decisions. What I have heard from this testimony to a great extent, the fraud is detected by individuals who know they didn't receive particular services yet the billing procedure oftentimes does not pass through the individual, so even if they were knowledgeable, which many of them are not nor should they be, even if they were aware of the procedures that were going on, which is very difficult to detect, the way in which we do it now would evade them anyway. Ultimately when you put it under a managed care structure, people can vote with their feet on the overall performance of the structure.

It is now impossible for people to carry out that kind of a relationship. And so you know, your information is useful. It confirms the fact that as we change the system in the larger sense of going to a performance criteria and volume controls, we have had a whole new area open up, not because it wasn't there before but because the people who couldn't make money in other areas were now looking to game the system under new areas.

And Mr. Mangano, in terms of your home health question, there is no question people are aging and no question technology is coming along. I think the real spiker for that curve were court decisions in which HCFA previously was able to deny certain services and the Congress has failed to pass law to match the court case which has opened up the opportunity for these people to be even cleverer than they have been in the past about bilking the system.

Let me ask you about MTS, the medical transaction system. Obviously Mr. Kleczka was talking about catching people in terms of getting a billing in one sense and crosswalking it to another. Would we have had the computer capability to track all of the inputs coming into the system, where are we on MTS?

Mr. STROPKO. I think we are about——

Chairman THOMAS. Would you identify yourself for the record?

Mr. STROPKO. Ed Stropko, Assistant Director, with the General Accounting Office. HCFA is 3 to 4 years from implementing MTS. They have fallen a little behind schedule but it is an important system for them to develop.

Chairman THOMAS. We are going to attempt to provide you with those administrative simplifications and computer capabilities as we move a modest reform bill. It should have been done in the 103d Congress, while people wanted to reinvent the world, we were unwilling to provide you with simple accounting tools which are currently available and more and more people are making use of.

In your testimony, Mr. Mangano, you referred to southern Florida. In terms of the kind of fraud and abuse that you have looked at, have you done sufficient studies to get a feel for the regionality of the fraud and abuse or is it that you just went to particular areas because you thought they were high in fraud and abuse?

Do you have any statement that you might want to make for the record on what you feel, if you are capable, of the regional abuse of the system?

Mr. MANGANO. Well, we are finding that south Florida is an area that is rising dramatically in the fraud and abuse area. We have just, with the very few resources we have had, we just increased the number of investigators we put down there.

The study I mentioned regarding home health services where we found 75 percent of those claimed were not appropriate, we are now doing a statewide survey which we should have complete in a relatively short timeframe to see whether the entire State of Florida has similar problems within that regard.

We are focusing a lot of attention on south Florida. The amount of dollars—it is one of the four top States in Medicare expenditures for the country, so you naturally would think it would have a high rate of fraud and abuse.

Chairman THOMAS. Thank you. Any additional questions?

I want to thank the panel very much for your testimony.

Mr. MANGANO. Thank you.

Chairman THOMAS. I would ask the third panel to come forward.

I understand we have a replacement for the American Hospital Association, Rick Pollack will substitute. Donald Lewers of the American Medical Association; Dr. Nelson Ford, Association of American Medical Colleges, Larry Gage for the National Association of Public Hospitals; and Dr. Paul Ebert for the American College of Surgeons.

We will start the testimony with Mr. Pollack.

STATEMENT OF DICK DAVIDSON AS PRESENTED BY RICHARD POLLACK, EXECUTIVE VICE PRESIDENT AND DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Mr. POLLACK. Thank you, Mr. Chairman.

We appreciate this opportunity to share our views. Mr. Chairman, there has been a tremendous political change in the country and nobody knows that better than you and your colleagues, and change is what we are here to talk about today.

America's hospitals and health care systems understand that change is needed in Medicare and we favor change if it brings better care to seniors and reduced cost to all citizens who help finance the program. But in bringing about changes, we also must not lose sight of the contract with America that was signed 30 years ago and that is Medicare.

We have heard from many people that they have pledged to protect Social Security from budget reductions while suggesting that Medicare is fair game. Yet for the elderly patients we serve, the fact of the matter is that Medicare is Social Security. For most seniors, the value of the Medicare benefit package is as important as Social Security. Medicare benefits are irreplaceable. They would not be available from any other source.

A large part of Medicare is funded through the same payroll tax as Social Security. Medicare is one of three Social Security trust funds and, like Social Security, Medicare expenditures for part A are supposed to be self-financed and not contribute to the Federal deficit. The bottom line is that Medicare and the people it serves deserve the same protection from political and budget deficit pressures as Social Security enjoys.

While we recognize that Medicare outlays continue to grow at a rapid pace, there are very legitimate reasons for those increases and we have detailed them in our written statement which is based on a recent study by Price Waterhouse that we would also be pleased to make available to the committee.

Having said that, we recognize that doesn't mean we don't have an obligation and responsibility to achieve efficiencies in Medicare. The fact of the matter is that the Hospital Insurance Trust Fund is expected to go bankrupt shortly after the turn of the century. That is why we must fundamentally rethink the way we deliver and finance services to its beneficiaries and how we govern the program if we are to keep it viable for the future.

In our view, there is a right way and there is a wrong way to achieve savings. The wrong way would be to continue business as usual—and that would involve more arbitrary cuts to providers and that would involve using those savings to finance other legislative agendas.

It is important to recognize that since OBRA 1987, medical hospital spending cuts of $48 billion have had a major impact. These actions will cause genuine hardship, particularly to many rural and inner-city urban hospitals who are already in financial peril. Data from 1992 show that hospitals lose 11 cents on the dollar for Medicare services. Clearly, continued ratcheting down of provider payments will exacerbate this already fragile situation. And even ProPAC says that there are limits to the ability of Medicare to reduce payment growth without hurting access to quality care.

To deal with the problems constructively and for the long term, we need to move the part A trust fund off-budget and out of the political crosshairs and then we need to make structural changes. We believe that moving toward coordinated care or managed care is the right way to change Medicare. As we have learned from the private sector, creating an efficient delivery system for Medicare beneficiaries must be a part of the solution.

More and more, coordinated care plans are providing services in a seamless fashion, both providing comprehensive benefits and no longer forcing seniors to bounce around from one unconnected facility to the next. In fact, a recent study found Medicare enrollees in coordinated plans just as satisfied with their overall care as those in fee-for-service, and CBO confirmed that coordinated plans can save money as recently as last week before the Senate Budget Committee.

One last point, Mr. Chairman. We also believe that we need to reexamine how we govern the Medicare program and its trust fund. We think that the best way to accomplish this is through the creation of an independent citizens' commission and a process which involves the following steps from a conceptual perspective. First, the commission would establish a benchmark of what level of funding is needed to maintain current commitments to the Nation's seniors.

Second, Congress would then establish a target for how much it wants to spend on Medicare.

Third, the commission would translate that number—through a process open to the public—into recommendations for a benefit package that those funds would support and the appropriate provider payments. Congress would then vote on this package in an up or down manner on a fast track basis.

In this way, we can have an open discussion about how much we want to spend and what we want to buy for those funds. It doesn't mean that the pressure would be off to achieve savings. What it does mean is that there would be an open process for balancing available resources with appropriate benefits. What it does mean is that Medicare spending decisions would be made on the basis of what is necessary to keep the program viable rather than using Medicare as the source to finance other legislative agendas.

So in closing, let me reiterate our commitment to change. Let me reiterate our commitment to work with you in a constructive manner to fundamentally rethink how we maintain that promise that was made 30 years ago to our Nation's elderly. And finally let me reiterate our hope that we do not resort to business as usual.

[The prepared statement of Mr. Davidson follows:]

American Hospital Association

AHA

Liberty Place
Washington Office
325 Seventh Street, N.W.
Suite 700
Washington, DC 20004-2802
202-638-1100

Statement
# of the
American Hospital Association
before the
House Ways and Means Committee
Subcommittee on Health
on
Medicare Budget Issues

February 6, 1995

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. I am pleased to testify today on behalf of AHA's 5,000 institutional and 50,000 individual members. The Medicare budget issues under consideration are crucial to the lives of older Americans. Hospitals and health systems believe that we have an obligation to be there when they need us. For many hospitals, health systems, and elderly Americans, that means that the federal government must live up to another Contract With America -- a contract signed 30 years ago: Medicare.

MEDICARE IS SOCIAL SECURITY

In all of the political debate and discussion about tax cuts and balanced budget amendments, one government program has remained off the table: Social Security. Many Democrats and Republicans have openly pledged to protect Social Security from budget reductions, while suggesting that Medicare is fair game.

We believe, however, that Medicare is Social Security, and that it deserves the same protection as Social Security. Medicare and Social Security are both "contracts" with our nation's elderly to provide health care and a measure of financial security. A significant portion of Medicare is funded through the same payroll tax as Social Security. Medicare is one of three Social Security trust funds. Medicare serves the same seniors as Social Security serves. Like Social Security, the Medicare trust fund is not adding to the federal deficit.

The Medicare benefits Americans receive are irreplaceable. They would not be available through any other source. And, for most seniors, the value of their Medicare package is as important as Social Security. In short, Medicare and the people who rely on it deserve the same protection from political and budgetary pressures as Social Security enjoys.

America's hospitals and health systems understand that there needs to be change. In fact, we are at the forefront of change in communities all across the country. We strongly favor change that will lead to better care for our nation's seniors and to reduced costs for all consumers.

However, in seeking to bring change to a program that admittedly needs to be fixed, we must be careful not to take short-term actions -- like further arbitrary spending cuts -- that could make long-term solutions harder to implement.

GROWTH IN MEDICARE SPENDING: THE REASONS BEHIND THE RHETORIC

There's no question that Medicare spending is growing. Many policymakers who want to arbitrarily slash Medicare spending will tell you that it is growing faster than other federal programs. And they are right. But it's important to take a closer look at why. The AHA commissioned a study by Price-Waterhouse that was released just over a week ago. We learned some very interesting things. For instance:

- Inflation and enrollment growth accounted for nearly 89 percent of Medicare spending growth since 1980.

- Growth in Medicare enrollment between 1980 and 1993 was double the rate of growth in the general population. At the same time, enrollees over 75 years old as a percentage of all elderly (over 65) grew to 43 percent in 1993 and are expected to reach nearly half by 2005.

- The proportion of Medicare spending on hospital care has declined from 70.2 percent in 1980 to 60.1 percent in 1993.

- Medicare hospital spending growth is lower than growth in Medicare spending for other services.

Since the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) was enacted, Medicare hospital spending cuts of at least $48 billion have had significant impact on hospitals and health systems. So have Prospective Payment System (PPS) payment rates that haven't kept up with inflation. On Medicare inpatient and outpatient care combined, 1992 data show hospitals losing 11 cents on the dollar.

We know in the last year hospital cost performance has improved -- hospitals are working hard to make that happen, and we understand there may be an improvement in hospitals' Medicare margins as a result. Despite this improvement on the cost side, hospitals' overall financial health is less rosy -- the bottom line is that nearly one-quarter of all hospitals are still operating in the red.

In the past, hospitals have coped with Medicare spending reductions by shifting costs -- by passing the difference on to other payers, like non-Medicare patients and their employers. But those days are fast disappearing.

Simply put, the market is shutting down the cost-shift option. Managed care contracts and a growing number of private insurers who negotiate discounted prices are making cost-shifting a thing of the past. This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or both. Either action takes us farther from our mission of providing the highest-quality health care to all the people we serve, including America's elderly.

MEDICARE PART A TRUST FUND IS IN JEOPARDY

While we are committed to working with you to achieve further efficiencies in the Medicare program, we will continue to oppose "business as usual:" further arbitrary spending reductions, and proposals that would substantially reduce or freeze the hospital update factor, or lower special payment adjustments like the indirect or direct medical education adjustment, or the disproportionate share adjustment.

Even ProPAC says there are limits to the ability of the Medicare program to further reduce the rate of increase in payments for inpatient hospital service without hurting access to quality care for beneficiaries. The commission says that continued Medicare support for the additional costs associated with teaching programs is especially necessary in the absence of explicit financial support for these activities from other payers. And the commission notes that continued Medicare support for hospitals that are truly isolated or that serve Medicare beneficiaries residing in underserved areas is necessary to ensure access to care. We agree.

To protect Medicare and its beneficiaries, Congress should protect the Hospital Insurance Trust Fund. Balanced budgets, tax cuts and increased defense spending are popular goals, but trust fund balances should not be used to meet those goals. We need to shore up that fund, not weaken it further. Under even the rosiest scenario of the fund's Board of Trustees, the Hospital Trust Fund will be insolvent by the year 2004; a more conservative estimate gives it until the year 2000.

To deal with the problem constructively, and for the long term, we first need to move the Part A trust fund off-budget and out of the political cross-hairs. Then, we need to make fundamental, structural changes in the Medicare program -- like moving it toward coordinated care.

MOVING MEDICARE INTO COORDINATED CARE

In communities all across the country, hospitals, health systems, physicians, health care practitioners, local agencies and business leaders are working together to make their communities healthier. They are forming partnerships that bring a more coordinated health care delivery system to people.

These partnerships -- or networks -- focus on community needs and address underlying problems that contribute to poor health. Networks ensure that the right care is available at the right time. Through cooperation and collaboration, networks reduce excessive duplication of services and technology.

By being paid a fixed, up-front fee per member, they have incentives to use resources for prevention, health education and community outreach. They can also save money. A Group Health Association of America study shows that coordinated care plans, on average, reduced their overall premiums 1.2 percent for 1995. After years of premium increases, these plans are headed in a new direction.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a recent survey by the consulting firm of Frederick/Schneiders found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those with fee-for-service insurance.

Most importantly, coordinated care networks can bring Medicare beneficiaries closer to a better vision of health care for the future: a connected health system, with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Moving the Medicare program toward coordinated care is an idea that makes sense and one that many people believe will save money for our health care system. Take a look at the tremendous change that is going on right now in the private sector and the impact this change has already had on health and health care costs. According to the most recent Congressional Budget Office (CBO) projections, a shift from fee-for-service health care to coordinated care in the Medicare and Medicaid programs would generate overall savings of about 8 percent.

Coordinated care works. It works better than the old-fashioned, fragmented system we must pull away from. And it can bring better, more efficient care to older Americans who entrust their health to Medicare. There are a number of options Congress could consider that would help move Medicare into coordinated care. Here are a few:

- **Fix the current methodology used to pay Medicare risk contractors** -- There is general agreement that the current payment system is flawed, and Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local area, which affects costs and the calculation of the AAPCC.

- **Model the Medicare program after the Federal Employees Health Benefit Program** -- For federal employees, the government makes a fixed contribution and the employee chooses from a wide variety of plans. Medicare could do the same on behalf of its beneficiaries if they choose to enroll in a coordinated care plan in the private sector.

- **Provide financial incentives for Medicare beneficiaries** who choose coordinated care options that are available in their area. These plans, offering comprehensive services at lower than current fee-for-service prices, give seniors better value for their Medicare dollars.

- **Explore new ways of paying coordinated care organizations that contract with Medicare** -- a new approach would allow plans in the same market area to bid competitively for Medicare contracts, for example. Bidding would have the effect of setting different market prices in local areas for Medicare coordinated care enrollees in a way that takes into account local costs and health care needs.

- **Expand the types of plans that Medicare beneficiaries can choose** -- Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or traditional fee-for-service providers. Medicare should also contract with the growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New types of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.

- **Provide seniors with more information on coordinated care plans** -- send a list of local coordinated care plans directly to beneficiaries and give them an annual report that compares coordinated care and fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.

- **Allow for an open enrollment period each year**, during which Medicare beneficiaries can elect to receive services from a coordinated care plan -- and make their choice of a managed care plan valid for one year instead of the current 30-day period, to enable the plan to better manage beneficiary needs and practice preventive care.

We are already seeing the beginnings of a transition to coordinated care for many seniors. In the longer-term, this can bring lower costs and more efficient health care to seniors, and ultimately restructure the Medicare program itself. But, what about the process under which Medicare budget decisions are made? That process has to change as well.

BRINGING FUNDING DECISIONS INTO THE SUNSHINE

The American people have a right to know that what their nation spends on Medicare is buying the best benefits and the most efficient care. They should rest assured that federal budget pressures won't get in the way of providing good health services for older Americans. AHA urges Congress to create an independent citizens' commission to do this job.

An independent commission would ensure that the people who rely on Medicare don't fall victim to political horse-trading or pressures to cut the deficit, cut taxes, or increase defense spending. Those pressures have led to congressional, back-room, middle-of-the-night Medicare cuts of $100 billion under the past two budget bills.

An independent commission would get the process out of the back rooms and into the sunshine. The commission would do an independent study on the spending needed to maintain current commitments. Then, Congress can set a target for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations -- which would then be voted up or down as a package.

This way we can have an open and honest discussion about how much we want to spend -- and what we can buy for that money. The commission would also provide an annual report to Congress on the quality of care and access to care under the Medicare program.

Creating an independent commission to make recommendations on Medicare spending and benefits doesn't mean that we won't constrain growth. It does mean that we'll do it rationally, in the full light of day.

CONCLUSION

There is a right way and a wrong way to achieve reasonable reductions in Medicare. The wrong way is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors. The right way is to restructure the program by providing seniors more choice and encouragement to participate in a broader range of coordinated health plans.

And the right way is to establish an independent national commission to make the tough choices that will be needed to keep services and benefits in line with available money -- and to keep Medicare from being a "cash cow" that continually finances other policy initiatives and legislative agendas.

America's hospitals and health systems look forward to working with this panel to create constructive change in the Medicare program -- and to protect the health care of elderly Americans that we all serve.

Chairman THOMAS. Mr. Pollack, thank you very much for your testimony.

Dr. Lewers.

STATEMENT OF DONALD T. LEWERS, M.D., BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. LEWERS. Mr. Chairman, members of the committee, thank you for the opportunity to testify today. I am Dr. Ted Lewers. I am a practicing nephrologist in eastern Maryland and a member of the AMA board of trustees.

In addition, for clarification, I am a Commissioner of the Physician Payment Review Commission, however, my testimony here today is based solely on the behalf of the AMA.

Thirty years ago, Congress enacted a pledge for America: The Medicare program. The program's three promises were that: First, government interference with medical care would be prohibited; second, patient choice of provider would be guaranteed; and third, options for people to protect themselves against the runaway cost of any health services would be preserved.

Americans put their trust in these three underlying guarantees of Medicare—autonomy, choice, and individual responsibility. Sadly, these principles have been eroded in recent years. Simply stated, budget-based reductions no longer work. A transformation of Medicare is required if we are to keep the pledge to Americans.

The answer is not simply to throw more money at Medicare, nor is the answer to continue slashing reimbursement levels. Serious and irreversible consequences to patient access to care could result from yet another series of cuts. Physicians have contributed their fair share to recent deficit reduction efforts.

Physicians account for 23 percent of Medicare outlays, but have absorbed 32 percent of the provider cuts over the last decade. Between 1981 and 1993, budgeted physician payments were cut by $39 billion. OBRA 1993 imposed an additional $47.4 billion in provider cuts. Yet even in the face of these cuts, physicians have succeeded in actually holding down the volume increases below the levels predicted. Physicians actually saved the program billions in budgeted dollars.

At its inception, part B was to have been 50-percent funded from general revenues; that number is now 72 percent. We can probably agree on some of the major factors that have brought us to this point: Demographics, new technology, increased demand for a wide range of health services, and a troubling number of fraudulent providers. But underpinning it all is a fundamentally flawed financing system that begs to be restructured.

The AMA is pleased to learn that Speaker Gingrich has considered the formation of a Medicare task force and we are hopeful it will include patients, practicing physicians, hospitals, and other providers. We urge Congress to build on the experience and expertise of PPRC, ProPAC, and other groups representing a variety of providers and patients and we welcome the opportunity to be a direct participant in this process.

The AMA believes that a meaningful transformation of Medicare must adhere to a few basic principles. First, we must encourage physician and beneficiary cost-consciousness. As you know, Mr.

Chairman, we worked with you, Chairman Archer, and Ranking Member Stark to develop patient protections during last year's health system reform debate. We urge this Congress to include patient protection act language in any reforms of the health system.

Second, we must facilitate price competition among providers to encourage economic efficiency.

Third, we must reduce intergenerational inequity in financing. The burgeoning "65 and over" group is putting a greater and greater burden on a shrinking working population.

Fourth, we need to think about ways to reduce the number of citizens who will be dependent on Medicare in the future.

The AMA supports the enactment of tax incentives for medical savings accounts and privatization using vouchers for beneficiaries to supplement the purchase of private insurance. Other options the AMA believes require further examination relate to the financial status of beneficiaries and the appropriateness of applying means testing or income rating to recipients.

Last, we need to reduce regulatory and administrative complexity. However, we urge caution. Short-term approaches alone will not solve the long-term structural problems of Medicare. Moreover, we cannot be oblivious to the wide variances in need for the elderly; those whose personal resources are inadequate must be helped to assure that their needs are met.

In conclusion, the need for a farsighted transformation of Medicare requires us to look beyond the immediate demand for quick fixes. The truth is that until Medicare's underlying financial dysfunction is addressed, my patients cannot be assured that I will be able to continue giving them the care they require. For my patients, the bottom line is not dollars, it is their health and the quality of their lives.

Physicians want to continue providing reliable quality care to the Medicare population, but we need your help. The physicians of the AMA pledge to work with you to find real answers to these complex problems so that we may all keep the Medicare promise.

Thank you, Mr. Chairman, for the opportunity to appear before you.

[The prepared statement and attachment follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health

Committee on Ways and Means

of the

U.S. House of Representatives

Presented by

Donald T. Lewers, MD

RE: FACTORS NECESSITATING THE TRANSFORMATION OF MEDICARE

February 6, 1995

Mr. Chairman, on behalf of the 300,000 physician and medical student members of the American Medical Association (AMA), I thank you for the opportunity to present testimony to the Health Subcommittee today. My name is Donald T. Lewers, MD. I am a practicing nephrologist in Easton, Maryland, and a Member of the AMA Board of Trustees. Today's topic of evaluating the root causes of the overwhelming growth in Medicare spending is a clear precursor to debate on the necessary transformation of the entire Medicare program. We applaud your leadership and that of the full Committee's chairman, Mr. Archer, in holding hearings at such an early date on this important topic.

Mr. Chairman, the AMA and its members are pleased with many elements of the Contract With America. At the same time, in the spirit of full and open debate we have already expressed to the Congress key areas where we urge caution or change as the legislative process moves forward. One of these areas is in rushing to make short-sighted budget cuts in the wake of passing the balanced budget constitutional amendment. For as important as that vote was, and as much as we supported it, we will all lose as a nation unless overwhelmingly important programs such as Medicare are not dealt with deliberately and fairly in the ensuing budget process. Surely, we should all agree that the promises we make to Americans this year will be consistent and build on those made in the recent past.

Thirty years ago, the Congress enacted a pledge for America's future: the Social Security Amendments of 1965 creating the Medicare program. The three fundamental and explicit promises of this health insurance program for the elderly and disabled were that government interference with the provision of medical care would be prohibited, that patient choice of provider would be guaranteed, and that the patient's option to secure "protection against the cost of any health services" would be preserved. These three guarantees -- autonomy, choice, and individual responsibility -- are the underlying principles on which the Medicare system was to be built and upon which the trust of Americans was placed.

Over time, these principles have been grievously eroded by expediency, by inattention, and most of all by repeated short-sighted efforts to prop up a fundamentally flawed financing system. The program began as an open-ended promise, not limited in financial amount or conditioned on financial need. Make no mistake, the program has achieved great success in meeting its objective of providing universal access to high quality medical care for elderly Americans. Today's Medicare patient is generally healthier, lives far longer and is more productive than his or her counterpart of thirty years ago. Physicians are proud of our key role in this record of success, and our goal is to build on these achievements.

Yet as all who study the program now know, Medicare spending has grown much more rapidly than initially projected, as services and populations have been added with an increased demand for the advances of modern health care technology. The growing financial burden of the program has led to increased taxes on working Americans and provider payment reductions that threaten the access to health care of the very citizens the program is designed to benefit. Clearly, basic reform of Medicare is urgently needed. The time to renew the original vows of the Medicare program has arrived in any legislation you craft in Congress this year.

BUDGET-BASED PROGRAM REDUCTIONS WILL NOT WORK

A transformation of Medicare is required if we are to keep our pledge to Americans. The answer is not simply to throw more money at Medicare. Nor is the answer to continue slashing reimbursement levels. A balanced budget cannot be "balanced" on the back of one program and those who provide that program's services. Serious, and perhaps irreversible, consequences to patient care could flow from yet another series of ill-considered cuts.

Last summer, John Eisenberg, MD, Chairman of the Physician Payment Review Commission (PPRC) established by Congress, was quoted in the New York Times as saying:

> "The problems in access to physician services for Medicare beneficiaries are just below the surface. People in areas underserved by doctors, members of minority groups and poor people already have the beginning of a problem. **This should be a red flag.**"

To put it simply, greater cuts could seriously harm Medicare patients. And the answer is not another round of huge Part B Medicare cuts; physicians have contributed their fair share to recent deficit reduction efforts. Consider, for example, the following facts: **physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade.** Between 1981 and 1993, budget reconciliation has been the vehicle for reducing Medicare baseline expenditures by some $98 billion. In this process, Medicare projected physician payments have been cut by $39 billion. Enactment of OBRA 93 alone imposed an additional $47.4 billion in provider cuts over five years for Medicare, including conversion factor cuts for 1994 and 1995. Even with these levels of cuts, **physicians have succeeded in actually holding down the volume increases below that predicted for 1991, 1992 and 1993, thus saving the program billions in projected dollars.**

We believe that Congress and the Administration should recognize physicians' recent success in moderating growth in Medicare expenditures for physician services. HCFA data indicates that Medicare expenditures for physician services increased by only 3% during FY93. In the two years preceding that, the average annual rates on Medicare physician spending was only 5.8%. Lower rates of growth in physician spending between 1989 and 1993 have reduced the Medicare baseline by $50 billion, **nearly as much as the total 1992 outlays for physician spending.** Physicians should be recognized for these savings and not be forced to shoulder inequitable burdens in another round of budget cuts.

Recent evidence from AMA's Center for Health Policy Research suggests that reimbursement rules set in place by OBRA 93 will cause a nosedive in physician payments later in this decade unless they are remedied now. While the trendline has increased during the first two years since enactment, by the end of the century physicians may be paid less than they are today for treating Medicare patients. This downward slope is from figures calculated without any adjustment for inflation; measured in real dollars, the decline would be even steeper. Thus, even without further legislative modifications to Medicare, payment amounts for physician services will be further reduced below their already inadequate level of 59 percent of private payers' rates.

FACTORS DRIVING MEDICARE GROWTH

We can probably agree on the major factors that have brought us to this perilous point: demographics, new technology, and an increased demand for a wide range of health care services. Underpinning it all, however, is a fundamentally flawed financing system that has gone largely unrecognized until the last decade.

- From 1967 (the initial complete year of program operation) to 1992, the number of enrollees served by the program increased from 19.5 million to 35.2 million.

- From 1967 to 1992, program expenses grew from $4.7 billion to $135.8 billion.

- From 1967 to 1992, the number of claims paid grew from 31.5 million to 496.5 million.

Demographic change has contributed significantly to Medicare's growth. The U.S. population has grown 31 percent since the inception of the program, while the percent of the population aged 65 and older grew by more than 50 percent. Life expectancy of the Medicare population has also increased by more than 14 percent for both males and females. Finally, the age distribution of the elderly has shifted toward an older average age, with the group aged 85 and older growing by 68 percent.

Technological progress in medical care is generally acknowledged as having been a significant factor behind Medicare expenditure growth. Technological advances since 1966, when Medicare was first implemented, have expanded the scope of diseases and conditions that are treatable, increased the treatments available and improved their efficacy and safety, made the treatments less painful and unpleasant, and have often decreased the recovery time necessary for a patient to be able to return to productivity. In recent years, estimates for the impact of new technology on expenditure growth are generally in the 15-17% range (PPRC 1993 estimate; AMA's Center for Health Policy Research 1992 estimate).

Significant growth also has occurred in the rate of use of services, in that the number of enrollees who use more services paid for by the program has increased markedly. The number of persons actually receiving services increased 118 percent between 1966 and 1993. At the same time, the average amount of services consumed by each enrollee receiving services increased 6.5 times. This increased rate of use and more expensive consumption served to increase the amount paid per enrollee by 1340 percent.

Other beneficiary demand factors have been suggested as driving a portion of Medicare's growth. These include growth in beneficiary income and reductions in out-of-pocket liability by way of: (1) increased Medigap coverage; (2) increased assignment of claims, combined with limits on balance billing; and (3) real rate reductions in the deductible. It is well known that patient utilization of services is directly related to the degree of cost sharing for those services. CBO research estimates that beneficiaries with Medigap coverage consume 24% more physician and hospital services than those without such supplementary coverage. Since more than 70% of beneficiaries own such policies (which essentially convert Medicare into first-dollar coverage), program expenditures are significantly increased by defeating the cost-sharing requirements of Medicare.

Finally, health provider fraud and abuse is responsible for some portion of Medicare's growth. Allegations of "upcoding" by physicians, and charges that physicians inflate the number of necessary visits by a Medicare patient are undoubtedly true among a very small percentage of "outliers." Researchers disagree about the effect of these few practitioners; while some have discovered some evidence of upcoding, for instance, others have produced studies repudiating any significant effect from such fringe practices. For example, PPRC's initial investigation of physician coding for evaluation and management services between 1991 and 1992 suggested that no upcoding had occurred (PPRC 1994). A summary of relevant literature prepared by the PPRC suggests a wide variation in estimates of the rate of inappropriate care, with most falling in the 5-20% range. (PPRC 1993). Despite the relatively small number of aberrant or "outlier" practitioners, the damage they do is enormous; the AMA has a zero-tolerance policy in dealing with these physicians. For its part in the battle against inappropriate physician activity and fraud, the AMA is currently working in conjunction with both the Department of Justice and the FBI in stepping up its assault on fraud and abuse within Medicare.

While the Part B Trust Fund is technically considered "actuarially sound," this determination is based on the fact that the Part B side of this entitlement program is financed largely from general revenues. When Medicare was enacted in 1965, general revenues were to have covered 50% of Part B expenses; yet, in 1993, general revenue contributions to the Part B trust fund amounted to about $41.6 billion, accounting for **71.9%** of total Part B program expenses ($57.8 billion in 1993). Premium payments accounted for approximately $14.2 billion, or about 24.6% of program revenue. Interest payments accounted for the remaining 3.5% of fund revenue.

In the twenty-five year period between 1967 and 1992, the program has increased in population by 80.3% (2.4% annual growth), program expenditures have increased by 2,767.7% (14.4% annual growth), and claims paid volume have increased by 1,477.7% (11.7% annual growth. This growth trend is certain to continue well into the future absent determined intervention. Last September, the Congressional Budget Office released figures projecting that Medicare spending will increase from $195 billion in 1994 to $434 billion by 2004.

PENDING BUDGET ACTION

When Speaker Newt Gingrich testified recently before your Committee regarding elements of the "Contract With America" within its jurisdiction, he supported the idea of a market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens. His emphasis was on how we can create the most competitive market-driven system for providing health care. He advocated using the Internal Revenue Code to provide incentives for people to "do the right thing." He mentioned professional autonomy, patient choice and individual responsibility -- coincidentally or not, the three promises of Medicare when it was originally enacted -- those same three promises that need so desperately to be reaffirmed today.

The Speaker's remarks should be heeded against the calls of those who would rush to reduce Medicare outlays to shore up the program. This simplistic budget-cutting approach has not resulted in cost-control over recent years, and now severely threatens the promised access of beneficiaries to medical care. The truth is that the Congress could come back every term and, facing intense political pressure, cut and cut payments for physician provided health care under Medicare, and we would still not have resolved the underlying financing dysfunction of the program as whole.

THE LONG TERM: MEDICARE TRANSFORMATION

With the potential for patient harm implicit in yet another round of budget cuts in Medicare, the AMA believes that a far different course of action is needed. Budget-based actions simply do not address the fact that the Medicare program is at a crossroads and headed toward a destructive major financial crisis early in the next decade. There simply won't be enough money in the Medicare fund to meet the health care needs of an aging population that is growing larger and larger and living longer and longer without fundamental reform.

In short, a major transformation of the Medicare program is required. This transformation cannot wait. Congress and the Administration should not settle for further short-term cuts at the margins or place an artificial cap on Medicare expenditures in the name of political expediency. The Medicare program urgently requires serious, lasting change if its promise is to be preserved for current and future generations of Americans.

The AMA is particularly pleased to learn that Speaker Newt Gingrich is considering the creation of a Medicare task force that would be managed by this Subcommittee's chairman, Representative Bill Thomas, and the full Committee's chairman, Representative Bill Archer -- both men of proven leadership and vision in the health system reform arena. We applaud the Speaker's explicitly inviting to the table "practical people who run real hospitals and practical doctors who see real patients and ... senior citizens who are directly involved." The AMA will do all it can to provide your task force with the timely and reliable information needed to consider the many options that undoubtedly will come under discussion, and would welcome the opportunity to be a direct participant in this process.

The AMA is prepared to enter into a new partnership in which all parties -- patient, physician, and the government -- work together to develop rational and effective long-term solutions to Medicare's financing problems. We support actions to reduce the expected growth of the program over time. In light of what is known about the program's structural flaws and its dismal prospects if basic reforms are not made, the AMA believes that efforts to formulate long-term reform must adhere to five basic principles:

> **Beneficiary cost-consciousness must be encouraged.** Medicare has deductibles and co-insurance provisions to encourage cost-consciousness. However, 70% of beneficiaries insulate themselves from these provisions by purchasing private supplementary coverage ("Medigap") policies which transform Medicare into first-dollar coverage. As a result, some beneficiaries consume more medical services than they otherwise would, costing the program substantially. The adverse impact of Medigap policies must be critically evaluated as they affect the long-term stability of the program. At the same time, we must be cautious about the burdens on the elderly.
>
> **Price competition among providers must be facilitated to increase economic efficiency.** Medicare payments to physicians and providers are determined in a way that provides little incentive for price competition. Without price competition, beneficiaries have no incentive to be price-conscious in choosing among providers. As patient choice is a bedrock of AMA policy and part of the original Medicare promise, options for selecting coverage and the providers to deliver services must be encouraged. Mechanisms that allow beneficiaries to

participate knowledgeably in their own health decisions on the basis of service, quality and price should be used in the program.

Intergenerational inequity in financing must be reduced. Medicare is funded by pay-as-you-go financing: current workers support the medical expenses of current beneficiaries. Not only are the elderly better off financially as a group than the working population, but the number of workers supporting each beneficiary will begin falling rapidly from four at the present time to two in the middle of the next century. The working population cannot be expected to willingly pay higher and higher taxes over this period -- especially if the long-term future of Medicare is in serious doubt.

Test ways of reducing dependency of future generations on Medicare. To reduce the burden of the program on future working generations and the federal Treasury, the number of beneficiaries should be minimized. Means-testing of benefits has been suggested as one approach; however, additional approaches also merit consideration. Incentives should be created for more people to work towards becoming financially independent of Medicare during retirement. Tax incentives to build Medical Savings Accounts (MSAs), tax-free accounts dedicated to medical expenses, including nursing home and long term care expenses, should be enacted. The availability of Medical Savings Accounts (MSAs) to be used for this first dollar coverage, in tandem with "catastrophic" coverage, would enhance patient choice and encourage individual responsibility, promoting two of the three foundations on which Medicare was originally established. These two measures -- means testing and MSAs -- are, to some extent, a part of "The American Dream Restoration Act" and "The Senior Citizens' Equity Act," both components of the Republican Contract With America that come under this Committee's jurisdiction. Another idea is that of offering vouchers to beneficiaries to supplement their purchase of private insurance, which may be more desirable to some individuals than Medicare coverage.

Reduce regulatory and administrative complexity. It has been estimated that physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations. This is time that could be used more productively treating patients. Furthermore, it is one of several factors (including low rates of payment) that discourages physicians from seeing Medicare patients.

These five basic principles should guide the design of any approach to reforming Medicare to correct current structural problems and to reduce the dependency of future generations on subsidized government medical care.

OPTIONS FOR MEDICARE REFORM

A few broad categories of reform have been advocated by an array of interests, both public and private, participating in the public dialogue on Medicare. The first category of reform, reduced coverage and benefits, takes a short-term view. Two others, structural reforms to contain costs and privatization, take the long-term view of transforming the system.

Short-term Options Which Affect Benefits and Coverage

The Bipartisan Commission on Entitlement and Tax Reform staff report presented a short-term approach to reducing Medicare spending which would restructure benefits and/or coverage. The Commission staff did not consider implementing cost containment initiatives in their report, an approach suggested by others for many years. Another set of options aim to privatize the system over various lengths of time. These are discussed in more detail below.

Numerous suggestions for restructuring eligibility and benefits were contained in the Bipartisan Commission staff report and have also been suggested by the Congressional Budget Office (CBO) in past reports to Congress. Suggestions for these types of cuts, accompanied by estimates of savings calculated for each option, are described in Attachment A to this testimony. Such approaches, if applied alone, will not solve the structural problems which must be addressed if program costs are to be contained. Moreover, any approach along these lines should be careful to differentiate between the elderly who have adequate resources and those who do not. For those whose resources are inadequate, such changes should be structured to assure that their needs are met.

Enhancing Intergenerational Equity in Financing

As indicated earlier in this testimony, the taxing of younger workers with modest incomes derived from employment to pay for the routine medical expenses of elderly beneficiaries with substantial assets is unfair as well as irrational. The working population, which is growing smaller in relation to the burgeoning "65 and older" group, cannot be expected to pay increasingly higher taxes when the long-term security of the Medicare program is in such jeopardy. A number of proposals to address this growing problem of intergenerational inequity have been advocated, including:

- means-testing of Part B premiums. The CBO has made a number of suggestions, such as to increase the Part B premium for individuals with an annual income greater than $100,000 and for couples with combined annual incomes greater than $125,000;
- revision of the eligibility age of 65. The arbitrary decision to select 65 as the age of eligibility when Medicare was created has even less justification today: it is a medical fact that the health status of the average 65 year old individual today is not comparable to that of a 65 year old in 1965; and
- reducing the dependency of future generations on Medicare and increase personal responsibility by encouraging the working population to accumulate savings in Medical Savings Accounts for medical care needs in retirement.

Long-term Structural Repairs Are Needed to Increase Efficiency

It is widely recognized that private Medigap insurance places a large financial burden on Medicare when beneficiaries with such coverage demand additional services because of reduced cost-sharing. The program should add insurance options for beneficiaries which ameliorate the effect of Medigap insurance on the Medicare program. Under this proposal, Medicare would combine the current Parts A and B by:

- offering two Federal insurance options to beneficiaries. Medicare Plan I would provide all current benefits without cost-sharing. Medicare Plan II would provide the same benefits, but would include reasonable deductible and coinsurance levels plus reasonable out-of-pocket annual caps on these amounts;
- setting the Plan I premium to be competitive with the current Medicare Part B premium plus the premium for a comparable Medicare supplemental insurance policy. The Plan II premium should be lower than the current Part B premium but the deductible should be higher by a compensating amount; and
- discouraging purchase of supplementary insurance covering Plan II services by requiring Medicare to be the secondary payor if a third party covers the Plan II cost-sharing provisions.

Another commonly proposed approach to dealing with the Medigap problem is to tax Medigap enough to recover the additional cost imposed on Medicare. One should note, though, that the CBO has estimated that a 100% or greater tax on Medigap premiums would have to be imposed to compensate the program for the additional cost.

Privatization of Medicare

Many, including the AMA, have proposed privatization approaches to the Medicare problem. Such a proposal would provide vouchers for beneficiaries to purchase private health insurance and encourage individual savings for retirement medical care needs which would reduce dependency on Medicare over the long-term. Features include:

- giving Medicare beneficiaries vouchers to purchase either existing Medicare coverage or health insurance with some other minimum prescribed benefits (beneficiaries must have the option to purchase additional coverage using their own funds);
- raising Medicare taxes to accumulate reserves sufficient to cover all future program costs by a certain future date; and

- expanding IRAs to provide supplemental funds for health care expenses on retirement (as provided in "The Senior Citizens' Equity Act" of the Contract With America) and creating tax incentives for establishing tax-free Medical Savings Accounts (MSAs).

Others have suggested that Medicare immediately provide vouchers to beneficiaries to purchase private health insurance, which would result in immediate privatization of the system. These proposals also necessitate some reforms of the private insurance system to assure that coverage is available to all beneficiaries. To summarize:

If the Present System is Phased Out:

- Experimental programs to test vouchers for private insurance
- Savings incentives to encourage financial independence in retirement and "prefunding" of medical expenses (as through MSAs)
- Incentives to create more coverage choices, including "catastrophic"

If the Present System is Retained:

- Reduce regulatory and administrative complexity
- Ameliorate Medigap impact on utilization increases
- Reform fee setting to stimulate price competition and economic efficiency
- Means-test benefits to eliminate unjust intergenerational inequity

CONCLUSION

In the process of advancing these systemic reforms, the AMA understands the demand to address the pressing needs of today. This is why we are undertaking two commitments to help reduce unnecessary spending in the Medicare program. We are stepping up efforts to reduce fraud and abuse and are working with the Department of Justice and the FBI. In addition, we recognize that physicians must take the lead in addressing "care at the margins" and "futile care" as death approaches; some of this care is wasteful and even unwanted. Physicians have an obligation to confront these unnecessary uses of Medicare resources. Part of the problem is educational, as patients, doctors, and health care institutions need to better understand the legal and ethical issues involved. The AMA is committed to clarifying these issues for physicians and patients.

Finally, before the Congress becomes immersed in the coming budget process and the battles over specific proposals, we need to accept the fact that Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care.

Americans who depend on the Medicare program for their health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. In the weeks and months ahead, the AMA pledges to work with the Congress to convince the American people that long-term reform is necessary and in the nation's best interest in order to keep the Medicare promise.

# # #

Summary of "Medicare Savings Through Reform: Options for Change"

prepared by:
The Center for Health Policy Research
American Medical Association
515 North State Street
Chicago, Illinois 60610

February 1995

Analysts have been studying a number of reform options and have projected fiscal savings associated with each. This report does not include all reform proposals that have been or should be considered; rather, it presents 16 incremental Medicare options for which savings estimates are readily available and timely.

Neither the options nor the estimates are new. The principal sources of material are the Congressional Budget Office and the Bipartisan Commission on Entitlement and Tax Reform final staff report. The options are sorted into two categories. Short term options assume implementation in fiscal year 1996, with savings estimates running to the year 2000. The long term options would, in most cases, also commence in 1996, but their savings implications are projected out to 2030.

Summary of Medicare Reform Options

Savings Estimates (by fiscal year, in millions of dollars)

SHORT RANGE OPTIONS

	1996	5-year 1996-2000
Beneficiary cost sharing:		
1. Increase and index Part B deductible	885	10,405
2. Raise coinsurance rate to 25% for Part B services	2,946	18,200
3. Collect 20% coinsurance for clinical laboratory tests, home health care, and skilled nursing facility benefits	3,349	29,826
4. Phase out Part B premium subsidy to 0% for high income enrollees	179	6,020
Medigap insurers:		
5. Tax medigap insurers	8,314	74,478

LONG RANGE OPTIONS

	2010	2030
Beneficiary cost sharing:		
6. Require a monthly Part A premium, indexed to program costs:		
a. $25 per month	22,053	97,522
b. $40 per month	35,285	159,937
c. $60 per month	51,457	237,955
7. Modify the Part B deductible for increases in program costs:		
a. Start indexing in 2000	5,881	39,009
b. Start indexing in 1996	10,291	58,513
c. Raise to $150 in 2000; index thereafter	8,821	54,613
d. Raise to $300 in 2000; index thereafter	11,762	58,513
8. Replace the Part B premium with a higher deductible:		
a. $800 deductible, indexed after 2000	0	50,712
b. $1200 deductible, indexed after 2000	17,642	128,730
	2010	2030
9. Index the Part B premium to maintain enrollees' current share of program costs	52,927	280,865
10. Phase in reduction of Part B premium subsidy for high income enrollees:		
a. Above $75,000 for couples ($50,000 for individuals)	7,351	35,108
b. Above $40,000 for couples ($30,000 for individuals)	19,113	89,721
11. Charge a 20% coinsurance payment for home health and clinical laboratory services	20,583	81,919

Beneficiary income taxes:		
12. Tax Medicare benefits as individual income:		
a. Include insurance value of Part A in income	30,874	136,531
b. Same as (a), for high income persons only	19,113	81,919
c. Include Part B subsidy in income	29,404	136,531
d. Same as (c), for high income persons only	17,642	81,919
13. Include the value of employer-paid health insurance and health care expenses in income for tax purposes:		
a. Benefits greater than average health insurance premium	64,689	249,658
b. Entire value of benefits	192,597	565,630
Eligibility age:		
14. Raise the eligibility age for Medicare:		
a. Match Social Security eligibility age	13,232	152,135
b. To 67 for persons under 46	20,583	152,135
c. To 68 for persons under 40	20,583	241,856
d. To 70 for persons under 28	20,583	401,793
Provider payments:		
15. Modify Medicare provider payments	69,100	358,883
Payroll taxes:		
16. Increase Part A payroll taxes:		
a. 1%	64,689	167,739
b. 2%	130,848	335,477
c. 3%	195,538	503,216
d. 4%	260,227	670,955

Chairman THOMAS. Thank you very much.
Dr. Ford.

STATEMENT OF NELSON FORD, CHIEF OPERATING OFFICER, GEORGETOWN UNIVERSITY MEDICAL CENTER, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. FORD. Thank you very much, Mr. Chairman. For the record, I am not a physician. I am Nelson Ford, the chief operating officer of the Georgetown University Medical Center.

Chairman THOMAS. Thank you.

Mr. FORD. I am here to testify on behalf of the Association of American Medical Colleges representing 126 accredited medical schools, 300 teaching hospitals, the faculty at these institutions, and over 160,000 students and residents in training to become our next generation of physicians.

I am here to testify on the vital importance of the Medicare program and the financial viability of the Nation's teaching hospitals and medical schools. I am concerned that many of the proposals under discussion today may affect that future viability. We have provided extensive testimony and I commend it to you.

I would like to focus on three issues of particular concern to us. The methodology of calculating the Medicare AAPCC for HMOs and its impact on teaching hospitals; the direct cost of residency training; and the crucial importance of the so-called indirect medical education adjustment on our future financial viability.

First, the Medicare AAPCC calculation has special payments in its base, including costs related to educational programs and disproportionate numbers of poor patients.

This provides additional revenue to precisely those health plans that may not use the types of hospitals for which the payment was intended. In fact, given the relatively higher costs of teaching hospitals and those serving the poor——

Chairman THOMAS. Mr. Ford, if I might interrupt, would you move that microphone more, and talk directly into it? We don't have good mikes for pick up. I appreciate it. Thank you.

Mr. FORD [continuing]. Puts the hospitals at a disadvantage in attracting Medicare patients. We recommend that the payments for teaching hospitals and the disproportionate share be excluded from the AAPCC calculation and that they be paid directly to the teaching hospitals that provide care to those managed care patients.

Second, with regard to the graduate medical education payments, we believe that the current methodology for Medicare's contribution to the costs of medical education, while not perfect, is generally fair and should be continued.

Proposals that suggest that the GME funding methodology be used to increase the number of primary care providers may prove to be ill conceived, particularly given that some research shows that there are sufficient numbers of primary care residency slots today to meet the foreseeable demand for primary care.

If the goal is simply budget reduction, we would argue that cutting Medicare support for training, just because some of the other insurance companies don't provide for these costs, is poor policy. A better policy would be to insure that all payers and all patients bear—who benefit from having high-quality, well-trained physicians, bear some portion of the costs of that training. This has been the general policy goal since the early seventies. We have yet to achieve it. We need to continue to work on it.

Finally, let me come to the proposals to reduce the Medicare IME support to teaching hospitals. As the history of this legislation shows, Congress has consistently recognized the higher cost of teaching care and has provided IME payments in an attempt to level the playingfield. The reasons for these differences in costs are several.

Teaching hospitals have more severely ill patients with more complicated diseases that require more care and incur higher costs for treatment. Second, teaching hospitals have to maintain a broader scope of services and specialized regional services for the completeness of our programs.

We want to avoid closing psychiatry, high-risk obstetrics, or the neonatal intensive care unit simply because they don't make economic sense. Third, students and residents order more ancillary tests, take more physicals, and require more nursing services and physician supervision, making our hospitals less efficient. Finally, teaching hospitals are where the advances in medicine are implemented. The transition from the lab to the bedside is hard and expensive and most insurance companies in the managed care business don't pay for those services.

I wonder where we would be without the past support of teaching hospitals for the development of bypass surgery or joint replacement or dialysis or cataract surgery or bone marrow transplantation. I wonder who will bear these costs in the future.

This role, which is a logical extension of the NIH's research mission, is critical to our future. At Georgetown last year we cut about 12 percent of our staff and we still expect to lose money. Our faculty salaries are going down. We are trying hard to expand our patient base to become more efficient and to work cooperatively with other providers in the community.

But I wouldn't be honest if I didn't tell you that the challenges we face are very real. All payers, government and private, are going to want to pay less for the services we provide. Our services are under pressure and we can't increase tuition anymore. I think we are making changes, but there is some limit to the rapidity with which we can streamline our operations.

There is not a right number for the Medicare IME adjustment, one that will precisely level the playingfield between all hospitals. But I think it would be wrong to target the one group of hospitals for extensive cuts that is responsible for the vast majority of our medical research, development and training, and I would urge you to exercise caution as you look at these issues in the future.

Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF NELSON FORD
ASSOCIATION OF AMERCIAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee, I am Nelson Ford, Chief Operating Officer of the Georgetown University Medical Center. The Association of American Medical Colleges (AAMC), which represents all of the nation's 126 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents welcomes the opportunity to testify on the importance of the Medicare program to the overall financial viability of teaching hospitals and medical schools. In 1992, nonfederal members of the Council of Teaching Hospitals (COTH) accounted for nearly 2 million Medicare discharges or almost 20 percent of all Medicare discharges.

All health care proposals are of concern to the nation's teaching hospitals, medical schools and teaching physicians. I am pleased to appear before you today to comment on four issues of particular interest to the academic medical community:

- the importance of the Medicare indirect medical education (IME) adjustment to the financial viability of teaching hospitals;
- the role of Medicare payments for direct graduate medical education (DGME) costs in support of residency training;
- the methodology for calculating the average adjusted per capita cost (AAPCC), the rate that the Medicare program pays to risk contractor HMOs; and
- the effect of a new volume performance standard on the medical staffs of teaching hospitals;

Academic medicine is in a period of momentous internal and external turmoil. Teaching hospitals, faculty practice plans and medical schools have recognized the need for change within their own organizations and are actively engaged in helping to reformulate the health service delivery system, find ways to reduce the rate of increase in health care costs, improve accountability, and maintain or improve the quality of clinical service. Teaching hospitals are studying ways to deliver services more efficiently through partnerships with other health care organizations and are seeking new arrangements with payers of services. Medical schools, often in conjunction with teaching hospitals, are working aggressively to: increase the number of generalist physicians; identify new community-based sites for physician education; enhance the curriculum to reflect both new knowledge and new delivery paradigms; and assure the vitality of biomedical and behavioral research.

Federal action to change Medicare payment policy comes at a most difficult time when academic medicine is making major efforts to adapt to a changing delivery system. Even under normal circumstances the four issues mentioned above would be important, but they take on especially critical dimensions in the current environment. While the academic medical community understands the Federal government's need and commitment to reducing the budget deficit and the growth in Medicare and Medicaid expenditures, teaching hospitals and teaching physicians would be particularly harmed just when they are undergoing major change to reflect societal need. For example, while many proposals to change Medicare payments would affect both teaching and nonteaching hospitals, reductions in IME and DGME payments would reduce Medicare payments to teaching hospitals, seriously threatening their financial stability, and affecting access to care and quality of care received by Medicare beneficiaries and other patients. Teaching hospitals and teaching physicians play critical roles in our health care delivery system, and they could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the education and service missions of academic medicine.

Although efforts to enact comprehensive national health care reform have stalled, the health care delivery system continues to evolve in a way that threatens the stability of academic medicine as both public and private payers struggle to control health care expenditures. In a competitive environment based on price, teaching hospitals and medical schools face special challenges because they have unique missions that, of necessity, add to their costs. Teaching hospitals are important components of the nation's health care system because they:

- provide all levels of patient care-from primary to tertiary services-often to the most disadvantaged members of our society;

- serve as primary sites for the clinical education of health professionals, including physicians, nurses and allied health professionals: and

- provide the environment for the conduct of clinical biomedical and behavioral research and the introduction of new technologies.

Because patient care, medical education, and research are conducted simultaneously, it is not possible to identify fully and uniquely the cost of each specialized activity. However, these additional missions of teaching hospitals leave substantial costs that must be borne in our current system by patient care revenues.

Last year, the AAMC actively supported efforts to achieve comprehensive health care reform, including the creation of all-payer funds for the missions and costs of teaching hospitals, a fund for the direct costs associated with the training of physicians, and a fund for the medical school costs supported historically by clinical revenue. In the current political environment, only incremental approaches to reform are likely to be offered, and proposals to change Medicare payment policy are likely to focus on reducing the Federal budget deficit However, the special challenges facing teaching hospitals and medical schools in a competitive environment still need to be addressed.

The AAMC believes that Congressional decisions on Medicare payment policy should be made in the context of their impact on the entire health care system. As the Prospective Payment Assessment Commission (ProPAC) indicated in its March 1994 report, "the Medicare program's responsibility to its enrollees is broader than merely paying for services for beneficiaries. This responsibility includes maintaining access to the quality of care and types of services available at teaching hospitals..."(page 56).

I urge the members of this subcommittee to consider carefully its Medicare payment policy recommendations for FY 1996. Particularly at this time, any change in Medicare payments to teaching hospitals and teaching physicians could undermine the overall financial viability of teaching hospitals and medical schools. Additionally, failure to address the way in which IME and DGME payments and the disproportionate share (DSH) payment are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals.

Indirect Medical Education (IME) Adjustment

The Purpose of the IME Adjustment

Since the inception of the Medicare prospective payment system (PPS) in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report. Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The IME adjustment is not to be confused with the Medicare payment for direct graduate medical education (DGME) costs, which also is part of the Medicare payment program. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS and include payments for residents' stipends and fringe benefits, faculty salaries and benefits, and allocated overhead costs. The AAMC's comments on direct graduate medical education payments are addressed later in this testimony.

The AAMC believes the IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals. To help ensure that the IME adjustment and its impact on teaching hospitals are understood, this testimony reviews:

- the purpose and history of the indirect medical education adjustment; and
- results of the AAMC's impact analysis of lowering the level of the adjustment.

First, however, a brief overview of the PPS is necessary to understand how the IME adjustment is calculated and why it serves a broader purpose than its name implies.

Overview of the Medicare Prospective Payment System

In December 1982, the Secretary of the Department of Health and Human Services (HHS) proposed a hospital prospective payment system for Medicare. Enacted in 1983, the system was intended to allow the Federal government to hold down health care expenditures and provide hospitals a financial incentive to deliver services efficiently. Hospitals and the Federal government would also benefit from the predictability of the flow of Medicare payments.

In contrast to the cost reimbursement system used for nearly twenty years, the PPS pays hospitals a fixed amount, determined in advance, for the care of Medicare patients in each of 490 valid diagnosis-related groups (DRGs). The DRG classification system distinguishes many important patient characteristics that are highly correlated with hospital costs, such as principal diagnosis, presence or absence of secondary diagnoses, and whether or not certain major surgical procedures were performed during the hospital stay. However, DRGs do not distinguish severity of illness within diagnostic groups nor do they account for many other characteristics that are likely to affect a patient's stay and costs, such as whether patients were transferred from other facilities.

Under the PPS, the amount of payment is determined by multiplying one of two standard, national prices (different for hospitals in Metropolitan Statistical Areas of over one million population and all other hospitals) by a DRG weighting factor that rates a particular DRG's complexity of treatment against the average Medicare case. Hospitals are at financial risk if the cost of treatment exceeds the DRG price, but they may retain the difference between the DRG-based price and the cost of delivering services for patients in given diagnostic groups.

The PPS balances the concept of a standard national price, which is intended to promote efficiency with the recognition that costs vary among hospitals, often due to factors beyond their control, such as location, types of patients, level of teaching activity, and share of low-income patients. As enacted and amended, PPS payments to hospitals are calculated using the standard national price per discharge and computing an individual hospital payment amount based on six factors:

- the location of the hospital determines the base rate paid for a discharge;
- the area wage level for each geographic location adjusts the base rate for labor differences;
- the hospital's case mix adjusts the payment for the types of patients that are treated in a facility as determined by their classification into DRGs;
- outlier payments for cases that have an extremely long length of stay or extraordinarily high costs partially compensate hospitals for the atypical severity of some patients;
- the disproportionate share (DSH) adjustment partially compensates hospitals for the above average costs of caring for the low-income individuals and the aged poor; and

- the IME adjustment compensates teaching hospitals for the cost impact of their special missions.

PPS payments to all hospitals are adjusted by the first three factors: location, area wage level, and case mix. Not all hospitals receive payments for outlier cases, or DSH or IME payments.

Since the PPS constituted a substantial departure from the previous cost-based reimbursement system, its implementation was phased in over several years. In the early years of the PPS, hospitals were paid a blend of their hospital-specific costs and a national standard rate. The IME adjustment was applied only to the Federal portion. By FFY 1988, hospitals were paid 100 percent on the national rate, and the IME adjustment was applied to the entire payment.

The History of the Indirect Medical Education Adjustment

The Origin of an Adjustment for the Increased Costs of Teaching Hospitals. In order to understand the origin and history of the IME adjustment, it is important to understand several events prior to implementation of the PPS, including the initial routine cost limits of the 1970s and how they were adjusted for teaching hospitals. Even though the Medicare program initially reimbursed all allowable costs of hospitals for the care of Medicare beneficiaries, the Federal government recognized that costs among types of hospitals varied, and soon imposed limits on the amount of variability that was acceptable to the program. Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) authorized the Secretary of Health, Education and Welfare to set payment limits on routine inpatient hospital costs. If a hospital's per diem costs were above the costs of comparable hospitals, those costs were not reimbursable under Medicare. The cost limits and the method of setting them evolved between 1974, when the regulations were first published, and 1979, when the cost limits were set at the 80th percentile of the costs of comparable hospitals, and hospital size, location (urban/rural), and area wage rates were taken into consideration in determining comparability among hospitals.

In 1979, when the Carter Administration sought to achieve some of its hospital cost containment objectives by further reducing Medicare payment limits, the teaching hospital community expressed concern that it would be harmed disproportionately. In response to this concern, government researchers studied the relationship between hospital costs and teaching status.

The researchers found that a hospital's intern and resident-to-bed ratio (IRB) was related to an increase in hospital costs, even when direct medical education costs such as residents' salaries were removed from the analysis. Using a statistical technique called regression analysis, analysts were able to predict the change in average Medicare cost per discharge (the dependent variable) associated with a given change in other factors, such as the intern and resident-to-bed ratio or area wages (the independent variables). The results of these empirical analyses provided statistical estimates of changes in average costs associated with changes in each independent variable. Throughout this testimony, the terms "empirical estimate" and "statistical estimate" refer solely to the results of such regression analyses.

Researchers found that routine costs per day in teaching hospitals increased on average 4.7 percent with each increase of 0.1 in residents per bed. As a result of these findings by government researchers, the Medicare routine cost limits for teaching hospitals were increased to incorporate a differential based on the intern and resident-to-bed ratio (IRB) in each hospital.

The adjustment for the costs of teaching hospitals was subsequently included in the extension of the routine cost limits to cover total operating costs per discharge as legislated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The magnitude of the adjustment was determined by a statistical analysis similar to the one used to set the adjustment to the routine limits.

The Adjustment for Teaching Hospital Costs Under the PPS. In the Secretary's December 1982 proposal for a new Medicare payment system, the resident-to-bed adjustment to the cost limits under TEFRA was converted to a PPS payment (the IME adjustment) to adjust for the higher costs of teaching hospitals:

> The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens... there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.
>
> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits... (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, Pages 48-49).

Using the results of a regression analysis, the Secretary's estimate indicated that Medicare operating cost per case increased approximately 5.79 percent with each 0.1 increase in the number of residents per bed. However, two months after the Secretary's report was issued, the Congressional Budget Office (CBO) presented an impact analysis of the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. CBO's estimate, as presented in Table A, shows that the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment had been set solely at the level suggested by the empirical estimate.

In response to the CBO analysis, the Administration suggested that the statistical estimate of 5.79 percent be doubled to 11.59 percent for each 0.1 increase in the IRB. The use of the regression estimates as a starting point resulted in an "empirically based" IME adjustment in the PPS. The doubling of the statistical estimate was accomplished by placing a multiplier at the beginning of the formula that calculates a hospital's IME adjustment factor. Congress supported this proposal of modifying the empirical estimate based on its expected impact on teaching hospital finances, and the empirically based IME adjustment was incorporated into the prospective payment legislation. The inclusion of the multiplier in the formula operationalizes the concept of the "empirically based" IME adjustment factor.

As more updated and refined information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available.

However, hospitals never actually received IME payments calculated at the 8.7 percent level because at the same time (1986) the DSH adjustment was added to the PPS. The IME adjustment factor was reduced by 0.6 percent to finance part of the DSH adjustment, resulting in an IME adjustment factor of 8.1 percent, rather than 8.7 percent, during the time the DSH adjustment would be in effect.

With the implementation of the DSH adjustment in 1986, policy makers and researchers recognized that while some hospitals would receive either IME or DSH payments, other hospitals would receive both. The 8.1 percent IME adjustment established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) recognized the possibility of the overlap in these payments. The DSH adjustment became a permanent part of the PPS with passage of OBRA 1993 (P.L. 103-66) in August 1993.

The current 7.7 percent IME adjustment, enacted in OBRA 1987, took effect on October 1, 1988. Table B shows the history of the IME adjustment.

Table A
Estimated Average Penalties and Bonuses Under the Administration's Proposed DRG-Based Payment System By Type of Hospital[a]

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[b]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[c]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[d]
All Hospitals	100	0[e]	61	+23	39	−12
Bed Size						
Less than 100	49	+23	80	+35	20	−10
100–299	34	+2	50	+21	50	−11
300+	17	−6	30	+17	70	−13
SMSA						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13
Teaching Status						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

b. Average calculated for all hospitals.

c. Average calculated for hospitals that would gain.

d. Average calculated for hospitals that would lose.

e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives
February 14, 1983

Table B
History of the Indirect Medical Education Adjustment

Time Period	Adjustment Factor (%)*
Oct. 1, 1983 - April 30, 1986	11.59
May 1, 1986 - Sept. 30, 1988	8.1
Oct. 1, 1988 - Present	7.7

* Applied only to the Federal portion of a hospital's PPS payment. This portion was 25 percent in Federal FY 1984 and 50 percent through April 30, 1986. Not until FY 1988 was the IME adjustment factor applied to 100 percent of a hospital's PPS payment.

The COBRA legislation modified the IME adjustment in a second very important way. In addition to a lower statistical estimate for the IME adjustment, the linear adjustment formula was respecified as a curvilinear formula. Therefore, as the resident-to-bed ratio rises, IME payments increase at a reduced rate.

Under the PPS, teaching hospitals receive IME payments as determined by their individual resident-to-bed ratios, the empirically based adjustment factor and the type of Medicare patient they treat. The percentage add-on to the DRG payment varies among individual hospitals depending on their resident-to-bed ratios. The average resident-to-bed ratio in the nation's teaching hospitals is about 0.10, or 10 residents for every 100 beds. Government researchers generally define major teaching hospitals as institutions with at least a 0.25 resident-to-bed ratio. Academic medical center hospitals[1] have an average resident-to-bed ratio of slightly over 0.50. For example, using the current IME adjustment factor of 7.7 percent, a hospital with a 0.05 resident-to-bed ratio would receive an additional 3.8 percent IME payment under the PPS. A hospital with a 0.25 resident-to-bed ratio would receive a 17.9 percent increase in the DRG payment and a hospital with a 0.50 resident-to-bed ratio would receive a 33.7 percent add-on payment. Therefore, as the IME adjustment has been reduced, hospitals with relatively high resident-to-bed ratios have experienced a greater percentage reduction in their IME payments than hospitals with lower resident-to-bed ratios.

The Interest in Teaching Hospitals' Financial Performance

Throughout the history of the PPS, the financial performance of teaching hospitals has been an additional consideration, beyond the statistical estimate generated by regression analysis, in determining the level of the IME adjustment. The first evidence of the importance of other factors in addition to the "statistical estimate" was the CBO impact analysis that documented how the proposed payment system would adversely affect teaching hospitals relative to nonteaching hospitals. This analysis resulted in the doubling of the statistical estimate.

As the Medicare PPS was gradually implemented, government bodies, private research economists, and the hospital industry began to monitor the impact of the new payment system on the nation's hospitals. Two closely watched measures of the impact of the PPS on hospitals were PPS margins (the losses or gains associated with Medicare cases paid under the PPS) and total margins (the losses or gains margin associated with all hospital operations, including all patient care and other income from investments and philanthropy). The Inspector General (IG) of the Department of Health and Human Services, the Congressional Budget Office and the Prospective Payment Assessment Commission (ProPAC), issued analyses of hospital PPS margins showing that, through the third year of PPS (1986-87), hospitals in general had fared well under PPS and that teaching hospitals had significantly higher PPS margins than did nonteaching hospitals.

In a statement submitted on August 1, 1988 to the House Budget Committee's Task Force on Health, the AAMC cited three factors that contributed to the unexpectedly high margins of teaching hospitals in the initial years of prospective payments:

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[1] Academic medical center hospitals are defined as hospitals under common ownership with a college of medicine or hospitals in which the department chairmen of the school of medicine also serve as the chiefs of service at the hospital.

- teaching hospitals maintained above average occupancy rates. In a fixed price payment system where revenue varies directly with volume, teaching hospital occupancy rates contributed to positive financial performance;

- HCFA's use of 1981 case mix indices to establish the hospital-specific payment component of the PPS resulted in an overstated hospital-specific price for use during the phase-in transition period; and

- the original IME adjustment was incorrectly interpreted as a linear relationship and was based on incomplete 1981 data.

When the inappropriateness of the linear form was recognized and when more updated information became available, the AAMC did not oppose a recalculation of the IME adjustment, i.e., a decrease in the empirically based adjustment from 11.59 to 8.1 percent and the imposition of a curvilinear form on the adjustment factor. Congress subsequently reduced the IME adjustment to 7.7 percent when the limit on DSH payments was removed. The AAMC did not oppose these changes in light of the empirical findings on hospital costs and the financial performance of teaching hospitals in the early years of the PPS.

Over the years the executive and legislative branches have proposed reductions in the level of the IME adjustment. These proposals have been based on calculations using a variety of regression models, more current data, and different combinations of variables. In January 1989 the General Accounting Office (GAO) issued a report that estimated the size of the IME adjustment using various regression specifications and called for a reduction in the level of the adjustment. Every year since 1989, the Prospective Payment Assessment Commission (ProPAC) has recommended a gradual reduction in the level of the adjustment.

In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and in making its recommendations has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of assuring roughly comparable total margins for teaching and nonteaching hospitals.

Last year, in making its recommendation to decrease the level of the IME adjustment to 7.0 percent for FY 1995, the commission urged caution in implementing a precipitous drop in the IME adjustment. While PPS inpatient operating margins for teaching hospitals are on average higher than those for nonteaching hospitals, teaching hospitals' total margins have remained consistently lower than other hospitals' total margins. As analyzed by ProPAC, data from the ninth-year of PPS (1992-93), the most complete information publicly available, show that average PPS margins for nonteaching hospitals were minus 6.4 percent, but total margins were plus 4.7 percent. Major teaching hospitals, however, posted PPS operating margins of 8.0 percent, but their average total margins were substantially lower at 3.0 percent. The average total margin for all hospitals was 4.1 percent.

A more recent ProPAC analysis of preliminary data from the tenth-year of PPS (1993-94) shows the same relationship between financial margins and teaching status. Major teaching hospitals, which are underrepresented in the incomplete tenth-year database, had PPS margins of 11.2 percent, but recorded average total margins of 1.8 percent. Other teaching hospitals, those with IRBs of less than 0.25, had average PPS margins of minus 0.8 percent and total margins of plus 4.4 percent. Nonteaching hospitals had the lowest PPS margins at minus 5.9 percent , but posted the highest total margins at plus 4.8 percent.

Some policy makers have maintained that a significant portion of the IME adjustment is intended to help defray uncompensated care costs. Further, they argue, in a reformed health care system in which more individuals are covered by health insurance, teaching hospitals' burden of uncompensated care would be reduced and would justify a significant reduction in IME payments. Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society. Yet their overall financial viability, on average, tends to be more precarious than nonteaching hospitals. The AAMC has noted repeatedly the purpose of the IME adjustment is not to provide financing for uncompensated care, but to recognize factors that increase costs in teaching hospitals. Analysis by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and nonteaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, services they offer, biomedical research they conduct, and residents they teach.

The AAMC's Impact Analysis of Reducing the IME Adjustment

The AAMC is greatly concerned that some policy makers have concluded that the IME adjustment could be reduced substantially without threatening the financial viability of teaching hospitals. The AAMC does not agree with this perspective and believes that a reduction of the IME adjustment would seriously undermine the financial stability of teaching hospitals. While a review of FY 1994 financial data supplied by 91 hospitals belonging to the AAMC's Council of Teaching Hospitals (COTH) suggests that some teaching hospitals are performing well financially, a closer examination reveals that their total margins have been relatively stable for three years and are comparable to the total margins of nonteaching hospitals. Increases in the average PPS margin have contributed to stable aggregate total margins over the period. Further analysis shows that any reduction in the IME adjustment would substantially harm teaching hospitals, destroying the "rough justice" that has been achieved with the current level of the IME adjustment.

Trends in PPS and Total Margins. PPS margins[2] for this group of 91 teaching hospitals, all but 19 of which are "major teaching" hospitals, increased in 1994. "Major teaching" hospitals are defined as those having resident-to-bed ratios of 0.25 or greater. Table C shows that average PPS margins increased from 3.70 percent in 1992 to 11.75 percent in 1994. Of the 91 hospitals in Table 1, 16 (18 percent) reported lower PPS margins in 1994 than in 1993. While 37 hospitals had negative PPS margins in 1992, only 15 hospitals had PPS margins less than zero in 1994. More importantly, however, the average total margin for this group has remained fairly stable (between 4.60 and 5.12 percent) over the three-year period.

PPS Margin Impact Analysis. Table D uses 1994 data to demonstrate the impact of various types of PPS payments on hospital margins and the effect of reducing the IME adjustment from its current 7.7 percent to 6.7 percent, 4.5 percent, and 3.0 percent. The 6.7 percent level is ProPAC's recommendation for FY 1996. It represents about one-third of the difference between the current level of the IME adjustment and the commission's most recent statistical estimate of 4.5 percent. The House Republican Alternative Budget for FY 1995, crafted last spring by the Republican members of the House Budget Committee led by current Budget Chair John Kasich (R-OH), proposed a reduction in the IME adjustment to 3.0 percent from its current level of 7.7 percent for every 0.1 increase in a hospital's intern and resident-to-bed ratio. To estimate the impact of a reduction in the IME adjustment to these various levels, a reduction factor was applied to each hospital's 1994 IME payment. This calculation assumes no change in the hospital's 1994 intern and resident-to-bed ratio and no other changes in Medicare payment policy.

Table D shows that teaching hospitals depend heavily on the IME and DSH payment adjustments to maintain their PPS margins. On average, PPS margins calculated without the IME or DSH payment adjustments--but with only DRG, outlier and "high ESRD use" payments--are minus 31.76 percent. The IME adjustment makes a significant contribution to

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[2] The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, outlier and "high End Stage Renal Disease [ESRD] use" payments) less Medicare inpatient operating costs, divided by PPS revenue. The PPS margin definition excludes Medicare revenues and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. Because payments for most of these cost components (except capital) are made on a cost reimbursement basis, the margins for these items cannot be positive. Therefore, the margins for Medicare inpatient beneficiaries are less than the PPS margins shown in this analysis. A more detailed discussion of the data and methodology used in this analysis is included as Attachment A.

TABLE C:
PPS AND TOTAL MARGINS IN SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS: FY 1992 - 1994
RANKED BY FY 1994 PPS MARGIN

HOSPITAL	FY 94 % MEDCAID CASES	FY 94 % MEDICARE PPS CASES	FY92 TOTAL MARGIN	FY 1993 TOTAL MARGIN	FY 1994 TOTAL MARGIN	FY92 PPS MARGIN	FY 93 PPS MARGIN	FY 94 PPS MARGIN
A	1.22 %	34.63 %	4.18 %	3.81 %	2.21 %	-9.15 %	-6.35 %	-26.39 %
B	0.06	33.69	-36.75	-16.30	0.25	-81.26	-49.63	-22.60
C	10.27	35.01	8.75	10.10	5.64	-9.76	-3.87	-15.87
D	34.79	25.81	3.23	0.15	3.91	-28.50	-23.16	-12.68
E	23.65	29.20	7.49	1.47	3.30	-3.78	-12.88	-8.08
F	12.19	27.81	2.76	2.79	-2.07	-6.62	-9.98	-7.88
G	6.33	21.74	3.00	2.99	2.13	-7.50	1.12	-5.12
H	15.63	37.82	4.28	5.63	4.86	-8.36	-4.45	-4.43
I	9.83	43.79	4.59	4.96	4.92	-8.50	-7.32	-3.33
J	3.71	47.89	4.13	4.60	7.23	8.42	11.91	-3.04
K	21.72	24.46	-2.29	4.00	3.40	0.14	-3.96	-2.69
L	20.75	31.15	11.35	10.24	4.07	-1.12	-3.77	-2.18
M	3.47	40.84	5.12	5.85	6.27	-10.27	-4.92	-1.81
N	15.88	32.03	2.98	0.13	1.03	-4.61	-10.00	-0.39
O	13.77	29.40	0.81	1.25	1.09	-9.29	-8.17	-0.24
P	6.34	52.10	2.78	-1.58	2.87	7.50	12.02	0.57
Q	0.00	42.43	6.40	4.44	6.60	-2.91	-2.58	2.13
R	39.90	20.63	10.45	6.26	4.56	-11.28	-6.31	2.29
S	7.40	21.63	1.12	-1.92	1.39	-15.79	-8.06	2.54
T	6.78	22.76	-3.32	1.47	0.06	9.15	4.03	2.71
U	16.52	38.39	8.65	11.18	12.48	8.22	3.22	2.94
V	23.50	25.11	0.58	-2.75	2.24	8.22	-0.82	2.98
W	7.78	29.28	6.68	6.03	-1.23	-6.52	-7.97	3.52
X	18.11	41.63	7.87	8.50	9.36	-5.16	-2.82	3.73
Y	15.57	37.06	4.41	5.59	3.82	-1.64	4.04	4.07
Z	28.90	31.32	3.34	1.40	14.71	-21.33	-19.21	4.37
AA	12.59	29.09	3.21	1.10	1.14	-9.47	-1.39	4.53
AB	31.44	24.97	9.97	8.25	10.34	-1.44	0.53	4.74
AC	6.92	18.54	10.44	7.80	5.09	9.41	-0.66	4.80
AD	21.47	22.42	7.25	5.71	11.43	8.60	4.58	5.16
AE	14.98	28.29	9.59	13.40	10.53	-6.15	2.66	5.18
AF	6.41	38.93	3.66	10.93	4.98	6.55	11.46	6.00
AG	19.08	32.53	5.03	5.26	6.25	3.56	7.79	6.24
AH	5.48	28.83	5.83	-4.90	7.92	-5.71	-20.50	6.58
AI	9.14	31.38	4.56	4.04	8.13	4.11	2.47	6.95
AJ	10.77	36.61	7.48	6.76	2.57	-1.77	-2.50	7.69
AK	19.80	36.20	1.39	5.22	7.11	0.91	8.97	8.48
AL	23.65	29.20	3.86	4.69	4.94	-6.33	1.55	8.66
AM	18.46	36.67	10.30	9.63	9.50	4.83	8.28	8.95
AN	18.08	26.51	0.63	0.84	7.24	-5.8	1.68	8.95
AO	70.78	9.32	2.18	3.31	2.47	5.10	-2.64	9.11
AP	33.63	25.78	5.27	5.24	5.77	10.80	6.29	10.98
AQ	27.27	26.36	-0.08	3.56	-0.39	12.97	10.21	10.98
AR	11.49	38.28	6.88	7.31	7.83	8.49	9.70	11.03
AS	28.20	21.54	5.30	4.56	7.40	-18.16	-19.54	12.04
AT	14.39	29.46	10.19	9.68	8.05	3.65	0.88	12.30
AU	6.71	54.51	6.26	6.98	5.23	-18.08	3.07	12.42
AV	61.33	10.12	10.66	14.51	1.31	26.08	18.89	12.63
AW	16.43	25.69	6.98	13.11	7.91	-2.00	6.97	12.97
AX	46.42	11.58	-6.14	-15.22	-2.05	17.03	23.31	13.39

TABLE C:
PPS AND TOTAL MARGINS IN SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS: FY 1992 - 1994
RANKED BY FY 1994 PPS MARGIN

HOSPITAL	FY 94 % MEDCAID CASES	FY 94 % MEDICARE PPS CASES	FY92 TOTAL MARGIN	FY 1993 TOTAL MARGIN	FY 1994 TOTAL MARGIN	FY92 PPS MARGIN	FY 93 PPS MARGIN	FY 94 PPS MARGIN
AY	27.34 %	19.66 %	2.84 %	-3.25 %	1.79 %	-2.10 %	-5.86 %	14.17 %
AZ	18.52	26.10	9.17	9.62	7.14	7.7	22.74	14.67
BA	13.78	21.75	4.55	3.80	2.60	-26.08	-3.87	15.30
BB	12.71	43.42	10.21	9.55	12.16	-0.09	4.43	15.51
BC	15.69	36.00	6.00	32.99	3.79	16.15	18.26	15.99
BD	22.26	25.83	12.08	22.14	21.33	3.64	16.00	16.07
BE	30.39	18.35	6.01	6.25	7.10	25.51	21.00	16.86
BF	27.19	17.87	12.80	14.21	6.68	-31.85	11.83	17.03
BG	14.24	42.61	3.96	2.47	1.91	5.67	10.55	17.12
BH	41.31	21.52	9.42	9.12	6.02	16.22	5.34	18.43
BI	24.10	24.20	-0.60	0.20	6.91	0.85	15.33	18.64
BJ	30.37	33.44	-0.29	0.94	3.76	4.77	15.72	19.16
BK	18.81	30.52	3.80	4.21	4.59	12.88	19.49	19.50
BL	24.54	19.73	4.94	4.93	4.05	11.19	11.56	19.51
BM	9.84	38.22	5.39	5.51	6.61	-1.54	9.57	19.77
BN	16.59	29.15	5.03	3.67	2.95	14.83	12.90	20.34
BO	18.93	33.07	7.34	4.41	4.52	12.85	11.92	20.47
BP	5.67	36.21	1.88	3.04	1.80	7.53	16.18	20.88
BQ	64.43	9.07	8.57	1.23	2.26	19.67	34.18	21.04
BR	47.46	16.71	-1.75	1.17	1.07	-8.88	17.52	21.14
BS	11.74	32.44	1.96	-3.10	4.73	17.34	10.55	21.19
BT	32.36	24.36	5.16	3.90	4.83	11.00	11.99	21.62
BU	45.58	15.08	5.67	11.28	14.30	25.92	17.81	21.78
BV	25.62	17.82	6.12	2.54	4.92	17.81	17.53	22.42
BW	12.52	27.74	7.36	7.01	6.87	10.95	17.33	22.47
BX	27.42	26.66	7.33	5.17	4.55	18.92	21.08	23.37
BY	22.72	23.53	4.57	6.05	2.97	14.94	17.89	24.11
BZ	36.86	29.64	7.07	7.54	4.47	20.20	19.64	24.34
CA	11.53	34.75	4.36	3.39	3.23	8.74	16.62	24.50
CB	33.16	21.83	7.73	5.70	7.79	25.83	26.75	25.38
CD	38.75	20.12	10.70	8.41	10.20	15.15	18.77	26.65
CC	53.97	11.50	-0.55	0.90	-2.89	28.39	29.96	27.06
CE	13.94	28.67	3.18	1.02	3.05	1.00	22.24	28.26
CF	16.47	25.16	2.79	2.07	2.85	15.39	20.06	28.76
CG	56.24	2.75	0.10	-1.37	12.21	19.80	25.58	30.43
CH	34.77	16.64	1.29	-1.18	2.60	-6.34	19.22	32.83
CI	49.20	12.98	-1.95	11.78	4.64	31.52	31.17	33.52
CJ	35.78	15.22	15.30	25.52	4.85	30.44	32.62	34.02
CK	36.62	15.60	6.92	3.94	-0.96	33.72	36.91	35.04
CL	44.95	4.79	5.21	7.66	6.42	34.97	34.89	35.67
CM	31.77	12.60	3.61	9.38	8.85	36.67	29.65	38.32
MEAN (Unweighted)	**22.58 %**	**27.40 %**	**4.60 %**	**5.12 %**	**5.11 %**	**3.70 %**	**7.31 %**	**11.75 %**
MEDIAN	**18.81**	**27.74**	**5.03**	**4.69**	**4.73**	**4.77**	**8.28**	**12.30**

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS.

TABLE D:
CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS' PPS MARGINS: FY 1994
RANKED BY DRG PAYMENT, OUTLIERS, ESRD, DSH & IME @ 7.7%

HOSPITAL	DRG PAYMENT LESS OPER COSTS	DRG PAYMENT PLUS OUTLIERS AND ESRD	DRG PAYMENT PLUS OUTLIERS & ESRD & IME	DRG PAYMENT PLUS OUTLIERS ESRD, IME @7.7% AND DSH	PPS MARGIN W/IME @ @6.7%	PPS MARGIN W/IME @ @4.5%	PPS MARGIN W/IME @ 3.0%
A	-87.41 %	-63.17 %	-34.97 %	-26.39 %	-29.11 %	-35.51 %	-40.25 %
B	-107.62	-41.30	-22.60	-22.60	-24.75	-29.74	-33.37
C	-46.59	-42.47	-15.87	-15.87	-18.75	-25.61	-30.77
D	-109.26	-96.12	-36.32	-12.68	-16.49	-25.86	-33.16
E	-67.64	-60.36	-19.74	-8.08	-11.39	-19.43	-25.61
F	-36.27	-29.21	-15.29	-7.88	-9.32	-12.60	-14.96
G	-63.09	-58.70	-13.46	-5.12	-8.85	-18.08	-25.32
H	-23.26	-17.50	-8.59	-4.43	-5.43	-7.69	-9.29
I	-19.36	-13.26	-3.33	-3.33	-4.52	-7.24	-9.18
J	-12.79	-10.44	-3.04	-3.04	-3.94	-5.99	-7.44
K	-58.38	-51.28	-12.50	-2.69	-5.92	-13.76	-19.81
L	-63.70	-57.64	-11.61	-2.18	-5.86	-14.95	-22.10
M	-43.74	-35.48	-1.81	-1.81	-5.21	-13.53	-20.01
N	-44.39	-33.39	-9.69	-0.39	-2.56	-7.67	-11.45
O	-62.93	-56.42	-5.35	-0.24	-4.46	-15.10	-23.69
P	-15.76	-13.00	0.57	0.57	-1.01	-4.65	-7.30
Q	-17.44	-12.51	-0.49	2.13	0.79	-2.29	-4.51
R	-76.38	-65.99	-15.47	2.29	-1.09	-9.42	-15.93
S	-49.28	-37.01	2.54	2.54	-1.26	-10.75	-18.31
T	-54.62	-43.82	0.93	2.71	-1.31	-11.44	-19.59
U	-15.77	-10.20	-1.91	2.94	2.03	-0.04	-1.50
V	-99.09	-67.16	-16.67	2.98	-0.30	-8.33	-14.59
W	-7.74	-5.52	-0.59	3.52	2.95	1.69	0.80
X	-32.48	-26.83	-12.47	3.73	2.50	-0.31	-2.32
Y	-30.74	-25.79	-0.02	4.07	1.56	-4.45	-9.00
Z	-71.32	-61.13	-21.88	4.37	1.93	-3.88	-8.26
AA	-27.87	-23.66	-1.60	4.53	2.40	-2.62	-6.36
AB	-69.80	-62.11	-13.28	4.74	1.50	-6.46	-12.68
AC	-10.82	-7.02	4.80	4.80	3.41	0.22	-2.08
AD	-54.75	-50.58	-9.75	5.16	2.18	-5.07	-10.66
AE	-44.76	-38.95	-0.36	5.18	1.83	-6.42	-12.90
AF	-39.61	-33.37	1.48	6.00	2.85	-4.87	-10.88
AG	-18.47	-14.12	-4.94	6.24	5.36	3.36	1.94
AH	-27.70	-23.29	6.58	6.58	3.54	-3.88	-9.63
AI	-48.23	-40.65	3.37	6.95	3.16	-6.37	-14.02
AJ	-11.56	-9.33	7.69	7.69	5.78	1.31	-2.00
AK	-53.99	-42.98	1.85	8.48	4.87	-4.17	-11.39
AL	-52.05	-46.54	0.33	8.66	5.04	-4.01	-11.24
AM	-54.20	-46.26	2.29	8.95	6.06	-0.99	-12.25
AN	-47.50	-36.59	-0.79	8.95	5.13	-4.48	-6.44
AO	-75.74	-68.71	-29.79	9.11	7.16	2.57	-0.83
AP	-71.15	-55.11	-4.42	10.98	7.63	-0.68	-7.26
AQ	-29.90	-24.66	-3.14	10.98	9.22	5.11	2.08
AR	-9.46	-7.96	7.39	11.03	9.42	5.68	2.94
AS	-46.07	-40.47	-2.18	12.04	9.28	2.54	-2.66
AT	-6.70	-1.99	6.95	12.30	11.35	9.19	7.65
AU	-1.34	0.97	12.42	12.42	11.08	8.00	5.77
AV	-74.30	-68.90	-29.81	12.63	10.83	6.58	3.45
AW	-45.36	-38.75	8.20	12.97	9.19	-0.41	-8.21
AX	-65.28	-55.25	-21.81	13.39	11.63	7.51	4.46
AY	-52.96	-42.24	-0.71	14.17	11.30	4.27	-1.20
AZ	-13.36	-9.41	4.59	14.67	13.39	10.41	8.27
BA	-55.68	-48.89	2.77	15.30	11.84	3.13	-3.86
BB	-32.36	-28.67	12.57	15.51	11.97	3.03	-4.19
BC	-15.75	-9.93	13.07	15.99	13.73	8.29	4.17

TABLE D:
CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS' PPS MARGINS: FY 1994
RANKED BY DRG PAYMENT, OUTLIERS, ESRD, DSH & IME @ 7.7%

HOSPITAL	DRG PAYMENT LESS OPER COSTS	DRG PAYMENT PLUS OUTLIERS AND ESRD	DRG PAYMENT PLUS OUTLIERS & ESRD & IME	DRG PAYMENT PLUS OUTLIERS ESRD, IME @7.7% AND DSH	PPS MARGIN W/IME @ @6.7%	PPS MARGIN W/IME @ @4.5%	PPS MARGIN W/IME @ 3.0%
BD	-66.61 %	-45.06 %	7.08 %	16.07 %	12.37 %	2.98 %	-4.67 %
BE	-45.17	-37.12	4.40	16.86	13.92	6.65	0.94
BF	-50.13	-45.74	-2.37	17.03	14.35	7.79	2.71
BG	-7.40	-3.20	12.75	17.12	15.51	11.73	8.96
BH	-91.25	-54.75	-2.09	18.43	15.44	8.04	2.20
BI	-9.24	-7.70	4.64	18.64	17.59	15.19	13.48
BJ	-15.12	-14.23	3.59	19.16	17.76	14.51	12.14
BK	-39.03	-33.53	11.44	19.50	16.16	7.76	0.99
BL	-50.57	-44.76	0.18	19.51	16.80	10.16	4.99
BM	5.26	6.54	19.77	19.77	18.27	14.76	12.18
BN	-27.85	-24.23	17.23	20.34	16.87	8.07	0.92
BO	-34.40	-30.30	12.10	20.47	17.30	9.38	3.04
BP	3.56	6.16	20.88	20.88	19.23	15.36	12.50
BQ	-50.39	-44.96	-14.14	21.04	19.50	15.90	13.25
BR	-61.49	-55.06	-0.59	21.14	18.22	10.95	5.21
BS	-32.27	-27.10	18.93	21.19	17.41	7.68	-0.38
BT	-32.78	-29.80	12.01	21.62	18.58	11.01	4.97
BU	-41.00	-36.56	-0.69	21.78	19.65	14.53	10.65
BV	-40.17	-37.90	8.20	22.42	19.46	12.10	6.25
BW	10.55	12.13	22.47	22.47	21.27	18.48	16.47
BX	-40.24	-32.73	11.94	23.37	20.33	12.75	6.69
BY	-28.21	-22.58	13.09	24.11	21.52	15.15	10.18
BZ	-39.53	-32.95	9.58	24.34	21.61	14.87	9.56
CA	-30.91	-2.31	19.08	24.50	22.53	17.84	14.30
CB	-38.64	-29.85	5.99	25.38	23.19	17.90	13.85
CD	-36.72	-31.83	6.92	26.65	24.37	18.83	14.56
CC	-38.10	-35.45	4.74	27.06	24.84	19.45	15.31
CE	-7.45	-4.89	25.90	28.26	25.51	18.65	13.20
CF	0.05	3.41	28.76	28.76	26.25	20.04	15.17
CG	-46.51	-35.50	4.91	30.43	28.40	23.49	19.74
CH	-26.39	-20.89	23.85	32.83	29.85	22.28	16.11
CI	-26.85	-23.40	9.16	33.52	31.81	27.72	24.64
CJ	-17.40	-15.96	12.61	34.02	32.38	28.49	25.57
CK	-27.73	-26.19	17.38	35.04	32.67	26.78	22.14
CL	-18.77	-9.96	19.10	35.67	33.86	29.51	26.20
CM	-11.44	-10.68	24.16	38.32	36.20	30.98	26.90
MEAN (Unweighted)	-39.39 %	-31.76 %	0.96 %	11.75 %	9.27 %	3.21 %	-1.49 %
MEDIAN	-39.03	-32.95	1.48	12.30	9.42	3.13	-0.83

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS.

reducing what would have been unsustainable large losses. increasing the average PPS margin from minus 31.76 to plus 0.96 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to plus 11.75 percent. If the IME adjustment is reduced from 7.7 to 3.0 percent, as proposed by the Republican members of the House Budget Committee, the average PPS margin would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points.

Most important, if the IME adjustment is reduced to 3.0 percent, the impact on average total margins would be substantial (data not shown in table). The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points. At the 6.7 percent IME level, the total margin would be 4.6 percent and it would be 3.5 percent if the level of the IME adjustment were 4.5 percent.

Contribution of the DSH Payment to PPS Margins. As the Medicare DSH adjustment has been expanded and increased (as mandated by OBRA 1989 and 1990), academic medical center (AMC) hospitals have come to rely increasingly on DSH payments as part of their total PPS payments. Table E below shows that DSH as a percentage of total PPS payments has more than tripled since 1988. On the other hand, the relative importance of the IME payment to a group of academic medical center hospitals has remained fairly stable since 1989. These data confirm the conclusion that can be drawn from Table D: the DSH payment increases the average PPS margin substantially. Moreover, one-third of the hospitals with negative PPS margins do not receive any DSH payment.

Table E
IME and DSH Payments as Percentages of Total PPS Payments in Selected Academic Medical Center Hospitals: FY 1988-FY 1994

Hospital Fiscal Year	IME as a % of Total PPS Payments	DSH as a % of Total PPS Payments	IME and DSH as a % of Total PPS Payments
FY 1988	19.6	3.9	23.5
FY 1989	23.7	5.2	28.9
FY 1990	23.4	6.3	29.7
FY 1991	24.5	10.8	35.3
FY 1992	24.6	11.9	36.5
FY 1993	24.7	12.7	37.4
FY 1994	25.4	12.9	38.3

Source: AAMC letters to Stuart H. Altman, Ph.D., Chairman, Prospective Payment Assessment Commission, 1989-1995.

It is expected that DSH will make an increasingly important contribution to total PPS payments, as OBRA 1990 mandated further DSH payment increases for FFY 1994 and 1995.

Discussion of the AAMC's Analysis. Now in its twelfth year, the current prospective payment system differs significantly from the original system, but it remains a payment system based on national average rates that do not by themselves recognize important differences in hospital costs. Thus, the IME adjustment, which recognizes the special characteristics of teaching hospitals, including the severity of illness of their patients, the range of services provided, and the presence of graduate medical education programs, is of great importance to teaching hospitals' financial stability.

The current IME policy appears to have created "rough justice" across hospital payment groups. The 1994 average total margin of this group of 91 COTH teaching hospitals is now comparable to the average total margin of hospitals that received only DSH payments (4.8 percent in ProPAC's June report) in the ninth-year of PPS and to hospitals that received neither DSH nor IME payments (4.6 percent) in PPS-9. ProPAC's recent analysis of an incomplete sample of hospitals reporting preliminary data from the tenth-year of PPS (1993-

94) shows that nonteaching hospitals' total margins appear to have stabilized at nearly 5 percent, about the same level as the total margins of this group of COTH hospitals.

ProPAC analysis of preliminary data from the tenth-year of PPS (1993-94) also shows that hospitals receiving both IME and DSH payments had the highest PPS margins (6.9 percent), but the lowest total margins (2.9 percent) of any payment group. Hospitals that received neither IME nor DSH payments had the lowest PPS margins (minus 8.0 percent), but the highest total margins (4.8 percent). Hospitals that received only DSH payments had similarly high total margins of 4.7 percent, and improved PPS margins of minus 3.1 percent. Hospitals that received only IME payments (and no DSH payment) had a lower average PPS margin of minus 3.3 percent, and a slightly lower total margin of 4.5 percent compared to DSH only hospitals and to hospitals that neither IME nor DSH payments.

For the COTH hospitals in this analysis, the average total margin has increased slightly over the three-year period. Recent Congressional mandates extending Medicaid coverage to broader populations who previously may have been categorized as indigent patients, combined with favorable changes in Medicaid payment policy, may have contributed to these hospitals' improved total margins during this period. However, recently mandated limits on the amount of Federal funding available for Medicaid disproportionate share payments will moderate or reverse this pattern. In addition, the continued growth in managed care arrangements, which often do not recognize the training and other special costs incurred by teaching hospitals, and pressure by third-party payers to discount high cost tertiary services threaten teaching hospitals' financial stability.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the higher patient care costs they incur as a result of the severity of their patients' illnesses, the scope of services provided and the impact of educational programs on hospital operating costs. However, its "medical education" label causes the adjustment to be viewed incorrectly as a payment for education only.

The IME adjustment was originally developed to create a "level playing field" for teaching and nonteaching hospitals. It serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;

- non-recognition of the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;

- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;

- unavoidable decreases in productivity stemming from the presence of trainees; and

- additional ancillary services ordered by trainees as they learn how to diagnose and treat patients.

The AAMC strongly supports the importance of considering other factors, such as financial impact, in addition to an empirical estimate in determining the level of the IME adjustment. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must also fulfill their unique educational and service missions, including provision of health care for the poor. The current IME adjustment of 7.7 percent for each 0.1 increase in the number of residents-to-beds represents a substantial reduction of over 30 percent, or nearly 4 percentage points, from the original adjustment of 11.59 percent. Teaching hospitals have coped with the decreased rate, but in the current health services delivery environment, they will not be able to withstand further reductions without making substantial changes in the programs and services that they offer.

A reduction in the IME adjustment would hinder teaching hospitals' capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units.

The AAMC continues to oppose any reduction in the indirect medical education adjustment and urges the Congress to consider carefully the impact of a reduction in the adjustment on all teaching hospitals.

Direct Graduate Medical Education Payments

Our present system for graduate medical education has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it may need in a reconfigured health care system. To that end, the AAMC has committed itself to identify ways to reverse the significant underrepresentation of generalist physicians among practitioners in the United States. A 1992 Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education and the practice environment to facilitate reaching the goal. Its foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the preferred methods of inducing career choices in certain specialties.

We may all agree that the imbalance between the number of generalist and specialist physicians is unacceptable to society. Some policy makers and others have argued that the federal government-particularly the Medicare program-should take a more active role in ameliorating this imbalance by changing the way that graduate medical education (GME) is financed. The Association's policy statement on the generalist physician strongly endorses that private sector organizations and governmental bodies should join together in partnership to eliminate the many barriers that exist to meeting the need for generalist physicians. First among these strategies is reducing the marked disparity in income expectations stemming from our current system of physician payment. A second strategy is the development of appropriate training experiences in ambulatory, community-based non-hospital settings. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training. With respect to the role of the Federal government, the AAMC policy statement recommends that:

- the Medicare program and other third-party payers should adopt other reforms in physician payment designed to compensate generalist physicians more equitably; and
- mechanisms employed to finance the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Some changes in direct GME funding will be required to encourage residency training in non-hospital sites and to provide the resources for other initiatives designed to make the generalist specialties more attractive to medical students. However, the AAMC does not believe that weighting Medicare hospital payments for graduate medical education by specialty or that moving to a national average payment for Medicare direct costs will have a positive effect on the decisions senior medical students make with respect to specialty choice. Medical students' career choices are not affected by payments made to hospitals. Before proceeding directly to the debate on these issues, I will provide some background on graduate medical education and its current method of financing.

The Environment for Graduate Medical Education

The nature of graduate medical education is changing. Many factors in the current environment are contributing to changes in how graduate medical education is conducted and how it may be financed in the future. Residency and fellowship education is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service. However, as hospitals increasingly are called on to improve efficiency, residency programs are under constant pressure to emphasize service over their educational role. Additionally, while graduate medical education is organized primarily in hospitals and has been focused mainly on inpatients, its involvement with ambulatory patients is increasing to reflect the shift from inpatient to outpatient care in the overall health care system. Many specialties are requiring residents to spend more training time in ambulatory settings. For example, the Residency Review Committee (RRC) for internal medicine has required that all trainees in internal medicine residency training programs spend at least 25 percent of their time in ambulatory settings.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. Graduate medical education has been funded primarily by patient service revenues to hospitals, with significant appropriations supporting some municipal- and state-supported hospitals and military and Veterans Affairs (VA) hospitals. While the Medicare program and some state Medicaid programs make explicit payments for GME costs, private payers have traditionally supported GME through the higher payments that they make to teaching hospitals for patient care services.

AAMC data show that, on average, hospital patient revenues supported 85.2 percent of resident stipends and benefits and 62.9 percent of clinical fellow stipends and benefits, excluding VA hospitals in 1992-93 (see Attachment B). If anything, these data overstate the role of the hospital in financing graduate medical education, particularly for subspecialty clinical fellows, who are often not funded by the hospital, and therefore may not be included in the institution's records.

Faced with pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even decline altogether to provide payments for graduate medical education costs. The costs associated with the training of physicians may not be recognized by payers as they shift to fixed price systems for defined "bundles" or packages of services, capitated payments, and negotiated contracts for selected services. Thus, the historic mechanism for financing graduate medical education is being steadily dismantled by the broader focus on price competition among health care providers.

The Purpose of the Medicare Direct Graduate Medical Education Payment

Hospitals that train health professionals have multiple functions. In addition to providing medical care to individual patients, these hospitals provide the resources for the clinical education of physicians, nurses, and allied health professionals. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213. 89th Congress. 1st Sess. 32 (1965) and Senate Report. Number 404. Pt. 1. 89th Congress. 1st Sess. 36 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the

> community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals for these costs.

The History of the Direct Graduate Medical Education Payment

During the 1970s the Congress authorized the Department of Health. Education and Welfare to set prospective limits on the amount of hospital costs that would be reimbursed by the Medicare program. In 1979, it was decided that in calculating these cost limits a hospital could exclude all DGME costs because it did not seem fair to compare the costs of nonteaching hospitals to teaching hospitals if the DGME costs were included. The costs of teaching hospitals would surely be higher. This exclusion set a precedent for separating DGME costs from other costs, a separation that carried over into the design of the Medicare prospective payment system in 1983:

> The Department [of Health and Human Services] believes that the direct costs of approved medical education programs should be excluded from the [PPS] rate and be reimbursed as per the present system. This approach will assure that the base rate is related to patient care outcome and not significantly influenced by factors whose experience is really based on objectives quite apart from the care of particular patients in a particular hospital (Secretary of the Department of Health and Human Services, Hospital Prospective Payment for Medicare: A Report to Congress, December 1982, pages 47-48.)

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a portion of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments were also open-ended in that there was no restriction on the number of years that Medicare reimbursement would financially support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology. The legislation changed the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five-year count would be suspended, however, for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Since the implementation of per resident payments in 1989, policy makers have proposed changes in the methodology to encourage residency training in generalist specialties and to limit the variation in hospital-specific per resident amounts. Generally speaking, these proposals also are intended to limit the growth in Medicare expenditures. Two proposals which will be addressed later in this testimony, weighting payments by specialty and constructing a national average payment amount, appear to have captured the attention of some policy makers. First, however, it is helpful to describe several recent government reports on Medicare financing of graduate medical education.

The Studies Conducted by the Inspector General and the General Accounting Office. Interest in changing Medicare DGME payments has been fueled to some degree by reports issued in 1994 by two government bodies: the Office of the Inspector General (IG) within the Department of Health and Human Services and the General Accounting Office (GAO). In an April 1994 report to the HCFA Administrator, the IG concluded, based on a sample of 120 teaching hospitals, that the per resident payment methodology caused the Medicare program "to share disproportionately in GME costs." The IG recommended that HCFA should propose several regulatory and legislative changes to more accurately identify Medicare's share of DGME costs, claiming that the pre-COBRA method was more comprehensive and representative of Medicare patients' utilization.

In July 1994, the IG issued its study of DGME costs, and recommended that HCFA re-evaluate its current policy of paying DGME costs for all specialties. The IG suggested that HCFA could submit a legislative proposal to "reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians." The IG noted that "with the financial difficulties facing Medicare, it can ill afford to be the primary financial support for educational costs associated with surplus physician specialists." The report explains that at the inception of the Medicare program, the nation had a physician shortage and there was little community financial support for physician training.

The GAO has sounded similar themes. In May 1994, the GAO concluded that hospitals were using Medicare funds to support a disproportionate number of nonprimary care physicians, rather than meeting "community needs" by training primary care physicians. The GAO also cited several barriers to primary care training, including restrictive Medicare payment rules regarding DGME payments. In October 1994, the GAO suggested that medical schools and residency programs were not doing enough to increase the number of primary care physicians and again urged Congress to modify Medicare payment rules to provide incentives for ambulatory training.

While the AAMC is encouraged that interest in GME reform to meet public needs remains high, the Association has serious concerns about the reports of both agencies. The GAO's October report does not rely on the most current information available. Medical schools have ignited a solid, positive trend of increased medical student interest in primary care since the period studied in the GAO's October report. Thousands of medical students at more than 98 percent of the nation's allopathic and osteopathic medical schools participated in National Primary Care Day last year. The findings of the AAMC's Medical School Graduation Questionnaire are corroborated by the results of the 1994 National Residency Matching Program, which shows that more medical school graduates are selecting training in the generalist specialties.

The AAMC's Office of the Generalist Physician has established a number of services to support the generalist programs of medical schools, including:

- co-sponsorship of National Primary Care Day;
- educational programs for medical school faculty and administrators designed to assist them in their efforts to strengthen generalist education at their institutions;
- studies to elucidate the factors affecting career choices of medical students and residents and monitoring outcomes of efforts undertaken by schools and programs;

- an information clearinghouse that contains published and unpublished reports of generalsit initiatives and experiences at various academic institutions; and

- annual surveys of all U.S. medical schools on their programs and/or initiatives to increase production of generalist physicians.

With respect to the IG's April report, the AAMC has not had the opportunity to study the technical issues raised in the document. While the AAMC supports the principle that the Medicare program should pay a proportionate share of DGME costs, it should be recognized that the base-year GME costs were audited by HCFA's fiscal intermediaries and in a number of instances, legitimate costs were disallowed. Congress should carefully consider technical changes which could reduce the program's current level of support for GME, particularly in light of diminishing support from other payers and the failure to establish an all-payer fund for graduate medical education.

The AAMC strongly disagrees with the IG's suggestion "to reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians." It would be a serious error to adjust the level and/or type of support based upon short-term circumstances in a rapidly changing health care system. This is particularly true of medical education with its extraordinarily long training cycle.

The IG's recommendation violates the intent of the original Medicare legislation which requires the program to support graduate medical education "until communities undertake to bear these [educational] costs." The AAMC strongly believes that in the current competitive environment, in which payers attempt to restrict themselves to paying only for those services they believe are necessary and reasonable for the care of their patients, communities have not undertaken to support the costs of physician training. In the absence of an all-payer fund for DGME costs, the Medicare program must continue to fulfill its original mandate and contribute its proportionate share to the education of physicians in all specialties.

Weighting DGME Payments by Specialty. For several years, some policy makers have proposed changes in Medicare payments for DGME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals would reduce the Medicare program's role in GME funding.

One payment proposal, made in 1993, would have based Medicare DGME payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighting of the national average resident's salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident's salary, down from the average weight of about 215 percent under current law.

If it had been adopted, this proposal would have replaced the current Medicare payment methodology for DGME costs with a system based on three national rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. Some policy analysts believe that these types of proposals would not only eliminate the variation in direct GME payments, but also would offer incentives to produce more primary care physicians. The proposal would attempt to accomplish this policy goal by paying relatively favorable amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies.

The Association opposes proposals that intend to stimulate the production of generalist physicians by weighting direct GME payments by specialty and length of training. Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe this proposal would achieve its intended objective of encouraging the training of more generalist physicians. Proposals to weight Medicare DGME payments by specialty would have a negative effect on most hospitals' Medicare payments for DGME costs, depending on the hospital's specialty mix of resident trainees.

There is no evidence that medical students' selection of residency training programs is related to Medicare payments to hospitals. The task at hand is not to increase the number of generalist training positions, but to increase the attractiveness of the training positions already available.

In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making. Finally, weighting would not sufficiently penalize institutions oriented toward subspecialty training.

The PPRC also "rejected as unwise the options of paying only for primary care positions or only for the first three years of training" (page 66). While the commission was aware of the need to increase the proportion of generalist physicians, it concluded that the nation will continue to require well-trained physicians in all specialties, and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

Proposals to weight payments by specialty would, however, eliminate the variation in the current per resident amount methodology across teaching hospitals and reduce support for physicians in training. There are legitimate reasons why there have been variations in institutional costs among residency training programs, including the way the law has been interpreted by the Medicare fiscal intermediaries and providers, and differences in historical funding sources.

It is important to understand the internal institutional dynamics that will result from the implementation of preferential weighting proposals. Those disciplines with an increased weighting factor will argue that they deserve "more" of the direct GME funds for their residency programs. At the same time, other disciplines, as a result of reductions in fee revenue attributable to the implementation of the resource-based relative value scale, are increasing pressure for more faculty salary support. Reports from members of the AAMC's Council of Teaching Hospitals indicate some specialty departments are approaching hospital executives for additional academic supervisory and administrative financial support.

While supporters of preferential weighting proposals indicate that a higher payment differential will be enacted only for primary care disciplines, it is likely many clinical specialties will argue they also deserve a "special weighting factor." It is unclear what criteria will be used to define a "primary care" program. The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal in 1991, and physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

The AAMC strongly supports more individuals entering generalist practice, but data on career choices of medical school graduates indicate that medical students' selection of residency training programs is not affected by Medicare payments to hospitals. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements, such as narrowing the income gap between generalist and non-generalist physicians, are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs. There are already a variety of federally-sponsored student loan repayment programs that could be bolstered.

Changes in physician manpower supply, pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policy makers in assuring the public has access to an appropriate specialty mix of physicians. The AAMC supports strategies to develop additional generalist physician manpower, but proposals to weight Medicare DGME payments based on specialty and length of training will only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Proposals to Pay a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some proposals recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC continues to be concerned about proposals to change Medicare DGME payments from a hospital-specific to a national average per resident payment. Such a proposed change likely would result in both a significant reduction in aggregate GME funding and a redistribution of DGME payments. Similarly, **the AAMC is opposed to proposals that would exclude certain types of DGME costs, such as faculty supervision costs or overhead costs, from the calculation of the Medicare per resident amount.**

The AAMC supports the continuation of the current Medicare per resident payment method based on hospital-specific costs. The AAMC believes a national average payment method would fail to recognize structural factors that legitimately affect a hospital's per resident costs. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including public subsidies and faculty practice earnings. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne by the medical school, or in some cases, the teaching hospital. The diversity of supporting the costs of faculty is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents; direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for maintenance and utilities. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

As noted earlier, in the current competitive environment, teaching hospitals' ability to cover the cost of physician education through those payers who are willing to pay higher prices has been severely limited because many public and private payers are increasingly restricting their payments only to the services that they believe are necessary for their beneficiaries. The AAMC believes that third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs.

Average Adjusted Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for covered lives, separating the payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare average adjusted per capita cost (AAPCC), the rate that the program pays to risk contractor HMOs, results in a payment system that creates an uneven playing field between teaching and nonteaching hospitals and may provide a disincentive for teaching hospitals to enter into contracts with Medicare risk-based HMOs.

The AAPCC calculation includes all Medicare fee-for-service expenditures, specifically the direct graduate medical education (DGME) payment, the indirect medical education (IME) payment and the disproportionate share (DSH) payment. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status.

Once these payments have been included in the AAPCC and paid to an HMO, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with HMOs because the HMOs receive the same AAPCC amount regardless of with whom the HMO has a contract. Teaching hospitals have higher patient care costs associated with their additional missions. The Medicare payment system recognizes these higher costs through the IME and the DSH adjustments and the DGME payment.

The AAMC believes that the IME, DSH and DGME payments should be excluded from the calculation of the risk payment rates and paid to a teaching hospital directly when the Medicare HMO enrollee actually incurs a bed day in the teaching facility. Simply put, if the teaching hospital provides the service, it should receive the IME, DSH and or DGME payments directly whether the service is provided to Medicare beneficiaries under the prospective payment system (which would include DGME costs), or through HMOs with risk contracts.

The AAMC urges the Congress to require the Prospective Payment Assessment Commission (ProPAC), as part of its analysis, to develop a methodology for removing these costs from the calculation of the AAPCC and for paying them directly to teaching hospitals when services are delivered to Medicare HMO patients. The Association is pleased that ProPAC has started to analyze how the Medicare program pays risk contractors. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding HMO use among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Medicare Physician Payments

Since 1991, specialty physicians in teaching settings have experienced significant fee reductions under the Medicare fee schedule system including reductions to procedure-oriented specialties, global surgical fees, bundled services for critical care, volume performance standards, outpatient site-of service limitations, and other payment policy changes for anesthesiology, pathology, and radiology services.

While the Association remains supportive of the original intent and philosophy of the Medicare Fee Schedule, the AAMC is concerned about proposed policies which may not assure appropriate levels of payment to all physicians. One proposal, first made in the Health Security Act, particularly concerns academic medicine.

A Volume Performance Standard for High Cost Medical Staffs

The AAMC is concerned that a deficit reduction bill may include a provision on high cost medical staffs. Under this provision, a new, rather punitive volume performance standard would be applied to medical staffs, holding them collectively responsible for all Medicare physician services delivered to inpatients. The performance standard would be defined in terms of volume per admission, measured as Relative Value Units (RVUs) per admission. RVUs per admission would be adjusted for case-mix using DRGs in the same manner as in the Medicare PPS for inpatient hospital services, except that the DRG weights would be based on physician, not hospital, services. The proposal also would make adjustments for teaching activity and disproportionate share status. According to the proposal's architects, the costs of physician services and hospital services would be linked for the first time.

Each year, the Health Care Financing Administration (HCFA) would calculate a hospital-specific volume per admission for each hospital in the country and rank these hospitals from the highest to the lowest. Limits would be defined in terms of the volume per admission of the median hospital. HCFA would recognize cost variation among urban-rural providers and adjust the hospital-specific volume accordingly. Initially the limit would be 125 percent of the national median for urban hospitals and 140 percent of the national median for rural hospitals. Similar to HMO withhold mechanisms, HCFA would impose a withhold of 15 percent of the payment for each physician service delivered by a high-cost medical staff, beginning in 1998. Reconciliations would be made the following year. For each medical staff below the limit, the entire withhold would be returned; for each staff above the limit, part or none of the withhold would be returned, depending upon the extent to which actual 1998 volume exceeded the limit.

Discussion of a New Volume Performance Standard for High Cost Medical Staffs. **The AAMC joins the PPRC, and several physician organizations, in opposing the extension of Medicare's volume performance standard (MVPS) to high cost medical staffs.** The fundamental premise of the proposal is that payment under the Medicare fee schedule should be treated like a managed care arrangement by establishing a prospective withhold mechanism. Congress intended that the Medicare Part B program remain a fee-for-service payment system for physicians. This intention was reconfirmed by enacting the Medicare fee schedule system in 1991. Therefore, to apply an HMO-styled prospective withhold of payments is not only inappropriate, but also fundamentally contrary to Congressional intent and every physician's participating agreement with the Medicare program. While the AAMC is supportive of refinements to the national VPS, as well as other positive incentives to reduce inappropriate physician care and Medicare Part B expenditures, the Association believes that this approach is flawed and would only serve to break trust between the physician community and the Medicare program.

This proposal would have a significant negative impact on both teaching and nonteaching physicians. First, the proposal assumes that a medical staff will behave like a cohesive medical group practice for the purpose of reducing Medicare inpatient payments. Typically, a medical staff behaves like loosely affiliated, autonomous physicians. As the PPRC discovered during its debate on the establishment of a national Medicare volume performance standard policy, there is little evidence to support the notion that a state, regional, or even a local level volume performance standard will provide a greater, more effective incentive for physicians to reduce costs than the national VPS.

Most teaching physicians' faculty practice plans are structured along departmental lines and by specialty. Although many are in development, integrated information systems to monitor and support cost and quality of care initiatives at the individual provider level and across departmental faculty practice plans are generally unavailable. Without these kinds of practice management tools, faculty practice plans (indeed all medical staffs) will not be able to identify high-cost providers, influence physician practice patterns, improve medical decision-making, and ultimately control the total cost of patient care.

The AAMC also believes that the methodology of the high cost medical staff proposal to equalize the services of physicians in teaching vs. non-teaching hospitals is flawed. Researchers have presumed that the services of residents, for the most part, are not billed by the supervising attending physician. Therefore, under a special rule, the hospital-specific per admission relative value for a teaching hospital's medical staff is adjusted to account for service volume generated by residents using a proxy. Architects of the high cost medical staff methodology state that this proxy measures the actual inpatient service costs of a resident's inpatient care which ordinarily be provided by attending physicians in teaching hospitals.

The AAMC is concerned that this measure could significantly distort the per admission relative value for physicians in teaching hospitals. This proposal fails to recognize the dynamics of physician billing in accordance with the provisions of IL-372 Guidelines and the attending physician criteria. The Association believes the methodology potentially overstates the costs of inpatient care by adding the GME equivalent per admission relative value to the service activity already billed by the attending physician supervising the resident's care. **The AAMC strongly recommends that the methodology for calculating the hospital-specific per admission relative value for teaching physicians, specifically the GME equivalent per admission relative value, be studied further.**

Conclusion

The AAMC regrets that Congress seems unprepared to enact comprehensive health care reform that includes all-payer funds for the special missions of teaching hospitals and medical schools. At the same time, all evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

Academic medicine consists of a diverse group of highly complex institutions providing the environment and resources for medical education and research for the nation and providing both basic and tertiary patient care services. The current emphasis on re-examining national policies in light of limited public resources places these institutions and their vital activities at risk if their special roles and nature are not appreciated.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. A poorly conceived or short-sighted policy to reduce Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure high quality health care, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the subcommittee and their staff to meet these common goals.

Attachment A

Data and Methodology

To assist in obtaining a better understanding of the importance of the IME adjustment to teaching hospitals and the negative effect of reducing the IME adjustment on hospital margins, the AAMC analyzed the financial data of 91 COTH members that provided Medicare Cost Report data for the three-year period. A list of the responding hospitals by state precedes the tables. Survey participants reported their data by hospital fiscal year. Thus, FY 1994 contains data from hospitals with fiscal years ending primarily in June 1994. Seventeen hospitals had fiscal years ending in other months in 1994. Hospitals with calendar fiscal year ends (December 1994), such as most hospitals in New York State, have been excluded from this analysis because their financial results are not yet available.

This analysis includes 61 academic medical center hospitals and 30 community teaching COTH hospitals. Seventy-two hospitals have intern and resident-to-bed ratios (IRBs) of 0.25 or greater, classifying them as "major teaching" hospitals. Nineteen respondents are "other teaching" hospitals with IRBs less than 0.25. In general, 1994 PPS data reported in these tables are from hospitals' "as filed" Medicare Cost Reports. Total margin (the margin from all hospital operations, including patient care, government appropriations, and other income from investments and philanthropy) percentages are calculated using data from 1994 audited financial statements.

Attachment A-1

COTH Hospitals Providing Data for 1994 IME Analysis

Hospital	City, State
Baptist Medical Centers	Birmingham, Alabama
University Medical Center	Tucson, Arizona
Kern Medical Center	Bakersfield, California
Valley Medical Center of Fresno	Fresno, California
Long Beach Memorial Medical Center	Long Beach, California
Cedars-Sinai Medical Center	Los Angeles, California
USC University Hospital	Los Angeles, California
Los Angeles County-USC Medical Center	Los Angeles, California
UCLA Medical Center	Los Angeles, California
University of California, Davis, Medical Center	Sacramento, California
University of California, San Diego, Medical Center	San Diego, California
The Medical Center at the University of California, San Francisco	San Francisco, California
University Hospital	Denver, Colorado
Georgetown University Hospital	Washington, D.C.
Howard University Hospital	Washington, D.C.
The George Washington University Hospital	Washington, D.C.
Washington Hospital Center	Washington, D.C.
Shands Hospital	Gainesville, Florida
Jackson Memorial Hospital	Miami, Florida
Tampa General Hospital	Tampa, Florida
Crawford Long Hospital of Emory University	Atlanta, Georgia
Emory University Hospital	Atlanta, Georgia
Medical College of Georgia Hospital and Clinics	Augusta, Georgia
MacNeal Hospital	Berwyn, Illinois
Mercy Hospital and Medical Center	Chicago, Illinois
Northwestern Memorial Hospital	Chicago, Illinois
Rush-Presbyterian-St. Luke's Medical Center	Chicago, Illinois
University of Chicago Hospitals	Chicago, Illinois
University of Illinois Hospital	Chicago, Illinois
Lutheran General Hospital	Park Ridge, Illinois
Memorial Medical Center	Springfield, Illinois
St. John's Hospital	Springfield, Illinois
Indiana University Hospitals	Indianapolis, Indiana
University of Iowa Hospitals and Clinics	Iowa City, Iowa
University of Kansas Hospital	Kansas City, Kansas
University Hospital, University of Kentucky Medical Center	Lexington, Kentucky
Alton Ochsner Medical Foundation	New Orleans, Louisiana
Tulane University Hospital and Clinic	New Orleans, Louisiana
Louisiana State University Hospital	Shreveport, Louisiana
Beth Israel Hospital	Boston, Massachusetts
Faulkner Hospital	Boston, Massachusetts
Mount Auburn Hospital	Cambridge, Massachusetts
University of Massachusetts Medical Center	Worcester, Massachusetts
University of Michigan Hospitals	Ann Arbor, Michigan
St. John Hospital and Medical Center	Detroit, Michigan
Blodgett Memorial Medical Center	Grand Rapids, Michigan

Attachment A-2

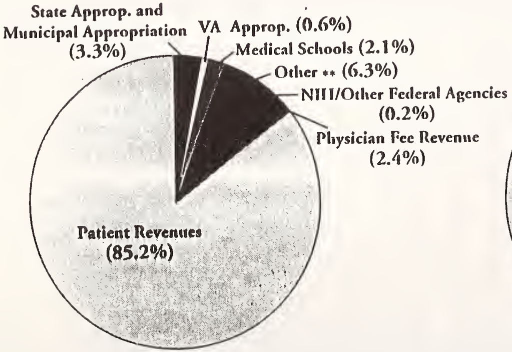
COTH Hospitals Providing Data for 1994 IME Analysis (Continued)

Hospital	City, State
Providence Hospital	Southfield, Michigan
The University of Minnesota Hospital and Clinic	Minneapolis, Minnesota
University Hospital, University of Mississippi Medical Center	Jackson, Mississippi
University of Missouri Hospital and Clinics	Columbia, Missouri
Truman Medical Center	Kansas City, Missouri
St. John's Mercy Medical Center	St. Louis, Missouri
St. Louis University Hospital	St. Louis, Missouri
University of Nebraska Hospital	Omaha, Nebraska
Mary Hitchcock Memorial Hospital	Hanover, New Hampshire
University of New Mexico Hospital	Albuquerque, New Mexico
University of North Carolina Hospital	Chapel Hill, North Carolina
Duke University Hospital	Durham, North Carolina
North Carolina Baptist Hospital, Inc.	Winston-Salem, North Carolina
University of Cincinnati Hospital	Cincinnati, Ohio
Grant Medical Center	Columbus, Ohio
The Ohio State University Hospitals	Columbus, Ohio
Medical College of Ohio Hospitals	Toledo, Ohio
Oklahoma Medical Center	Oklahoma City, Oklahoma
Saint Francis Hospital	Tulsa, Oklahoma
Oregon Health Sciences University Hospital	Portland, Oregon
Lehigh Valley Hospital	Allentown, Pennsylvania
Crozer-Chester Medical Center	Chester, Pennsylvania
Geisinger Medical Center	Danville, Pennsylvania
PennState University Hospital, Milton S. Hershey Medical Center	Hershey, Pennsylvania
Albert Einstein Medical Center	Philadelphia, Pennsylvania
Frankford Hospital of the City of Philadelphia	Philadelphia, Pennsylvania
Graduate Hospital	Philadelphia, Pennsylvania
Hospital of the University of Pennsylvania	Philadelphia, Pennsylvania
Pennsylvania Hospital	Philadelphia, Pennsylvania
Temple University Hospital	Philadelphia, Pennsylvania
Thomas Jefferson University Hospital	Philadelphia, Pennsylvania
Allegheny General Hospital	Pittsburgh, Pennsylvania
Shadyside Hospital	Pittsburgh, Pennsylvania
The Western Pennsylvania Hospital	Pittsburgh, Pennsylvania
Medical University Hospital	Charleston, South Carolina
Regional Medical Center at Memphis	Memphis, Tennessee
Vanderbilt University Hospital	Nashville, Tennessee
Methodist Hospitals of Dallas	Dallas, Texas
Harris County Hospital District	Houston, Texas
University of Utah Hospital	Salt Lake City, UT
University of Virginia Hospitals	Charlottesville, Virginia
Norfolk General Hospital	Norfolk, Virginia
Harborview Medical Center, University of Washington Hospitals	Seattle, Washington
University of Washington Medical Center	Seattle, Washington
University of Wisconsin Hospital and Clinic	Madison, Wisconsin

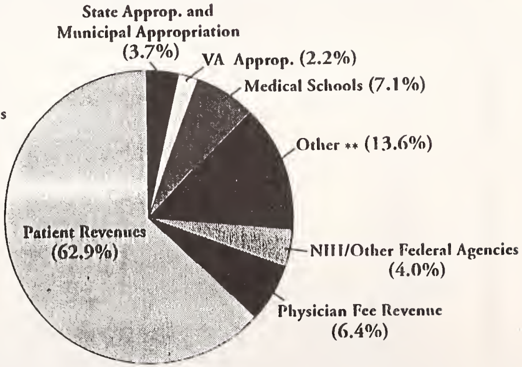
Attachment B

Source of Funding for Housestaff Stipends and Benefits All Hospitals, 1992-93*

Resident Stipends and Benefits



Clinical Fellow Stipends and Benefits



* Excludes Veterans Administration hospitals

** Includes endowment income and foundation grants

Source: COTH Survey of Housestaff Stipends, Benefits and Funding

Chairman THOMAS. Thank you, Mr. Ford.
Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman. I am Larry Gage, President of the National Association of Public Hospitals.

NAPH's members include over 100 of America's metropolitan area safety-net hospitals, with combined gross revenues of over $16 billion. These hospitals provide nearly 90 percent of their services to Medicare, Medicaid, and low-income uninsured and underinsured patients.

They also provide many preventive, primary, and costly tertiary services to their entire communities, not just to the poor. These include maintaining a wide variety of round the clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services and crisis response units for both natural and manmade disasters.

I recognize that this hearing is focused primarily on rising Medicare costs. With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are also concerned about rising costs. As we stated time after time last year, and as Stuart Altman pointed out earlier today, our current methods of financing and providing health care for the uninsured poor, and underwriting many expensive communitywide services, are both fragmented and fragile. We too are constantly searching for ways to pay for, as well as to provide, these vital services.

In the few minutes remaining to me, I would like to give you an idea of the possible impact on these essential providers of the substantial reductions in Medicare disproportionate share hospital and medical education payments that have been suggested by some this year.

Let me first briefly share with you a few statistics about the volume and financing of uncompensated care and communitywide services. I have charts that show tables that are attached to my prepared testimony. Very simply, table 1 on the right identifies the source of gross revenues for NAPH member hospitals in 1991, indicating that 88 percent were attributable to Medicare, Medicaid, and self-pay or no-paying patients.

Table 2 provides the same breakdown for outpatient and emergency visits, showing in both cases that 33–37 percent of all of our services are provided to the uninsured.

Table 3 on the far left identifies both the total volume of outpatient and emergency room visits provided by just 13 of the larger NAPH member hospitals, as well as the substantial proportion of those services that are not compensated by Medicare, Medicaid, or any other third-party payer.

As you see, these 13 hospitals alone provided over 6.8 million outpatient department and emergency room visits, of which 45 percent were uncompensated. Just to take a random example, the Kern County Medical Center provided nearly 30 percent of all of its outpatient visits on an uncompensated basis.

Finally, table 4, which is now in the middle, provides nearly 50 examples, and again, this is attached to my testimony, of the kinds of additional, often unfunded, services provided by these essential providers.

My point is this: In the absence of systemwide reform or universal coverage, this high volume of uncompensated care and these dozens of unfunded communitywide services can only be funded through the kind of institutionalized cost shifting represented by Medicare disproportionate share and medical education payments.

In 1993, for example, an as yet uncompleted survey of NAPH members preliminarily found that just 48 hospitals collected over $210 million in Medicare disproportionate share payments and nearly $270 million in direct and indirect GME payments.

If the disproportionate share payments were reduced by half and GME payments by approximately 40 percent, as some have proposed, this would be reduced to just $260 million. Since there are equal, if not greater, pressures on Medicaid and direct local subsidies, the other two primary sources of support, no other sources of funding are likely to be available to make up this loss of $260 million. And the results will be dramatic.

To give you an example, the $260 million is enough to fund 3 million uncompensated outpatient visits, or 100 percent of the standby costs of all of the 24-hour poison control, high-risk pregnancy, substance abuse, rape crisis, mental health, tuberculosis, and other services provided by these institutions.

In conclusion, we agree with what Rick Pollack and others have said earlier, Americans clearly spoke in November about their concerns for runaway government spending and programs, but it is important, we think, to ask the right question. We believe that question is not how rapidly can we reduce all governmental spending in all programs, but rather, how best can we determine what is the most appropriate role for government in an era of limited resources?

Thank you very much.

[The prepared statement and attachments follow:]

Statement of Larry S. Gage
President

National Association of Public Hospitals

before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington D.C.
February 6, 1995

I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $16 billion, these hospitals provide nearly 90% of their services to Medicare, Medicaid and low income uninsured and underinsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just the poor and elderly. These include maintaining a wide variety of round-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

In just the last two years, NAPH members have been at the forefront of the response to community wide crises that have included fires, floods, earthquakes, deadly new viruses, measles epidemics, environmental spills, air crashes, and urban riots. At the same time, their preventive and primary care services have been essential to meeting the day to day health needs of many millions of urban residents with restricted access to "mainstream" health services. In other words, these essential health systems -- which rely on Medicare, Medicaid and direct state and local governmental subsidies for over three quarters of their operating revenues -- already serve as a "national health system" by default in most of our nation's urban areas.

I am pleased to have this opportunity to testify before the Subcommittee on Medicare budget issues generally, and those aspects of the Medicare program that directly affect America's essential providers in particular. NAPH recognizes that the primary purpose of this hearing is to consider ways to curb the continuing growth in Medicare costs. We agree with the AHA and other witnesses testifying today that the hospital industry generally has not been the cause of recent growth in the Medicare program. In addition, those hospital payments that are most vital to essential providers -- such as disproportionate share hospital payments and medical education adjustments -- have also remained stable, with little growth, in recent years.

With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are also concerned with rising health costs. As we stated time after time last year, our current methods of financing and providing health care for the uninsured poor, and underwriting many expensive community-wide services, are both fragmented and fragile. For this reason, last year, when the Congress extensively considered alternative health plans, NAPH was willing to support various kinds of adjustments to Medicare spending, in order to obtain a more rational system in which the uninsured would finally receive health coverage. In the absence of such a goal, however, all current sources of safety net funding -- including the Medicare DSH and medical education adjustments -- are more essential than ever, especially for the highest volume providers of care to the uninsured and community-wide public health services.

NAPH has been gratified that the Congress has often achieved a bipartisan recognition of the importance of preserving and protecting these institutions. Throughout the mid-1980s, despite a number of reductions in the rate of increase in Medicare rates and medical education payments, the Medicare DSH adjustment was actually increased in a carefully targeted way for the highest volume providers of safety net services. Even last year, in the context of health care reform, this subcommittee voted unanimously, by an 11-0 roll call, to extend protections to these health systems and certain other "essential community providers". In terms of health reform, it has been stated by many observers that the most we may be able to achieve this year is modest incremental reform. In the absence of any likely movement toward universal coverage, the continued protection and support for safety net health systems is more essential than ever.

It may be helpful to give you an idea of the possible impact on these essential providers of some of the substantial reductions in Medicare DSH and medical education payments that have been suggested this year. Let me first share with you a few statistics about the volume (and financing) of uncompensated care and community-wide services provided by these health systems.

Table 1 identifies the source of gross revenues for NAPH member hospitals in 1991, and indicates that 88% were attributable to Medicare, Medicaid or "self-pay" (i.e., "non-paying") patients. Table 2 provides the same breakdown for outpatient and emergency visits.

Table 3 identifies both the total volume of inpatient services and outpatient/emergency room visits provided by 13 of the larger NAPH member hospitals, as well as the substantial proportion of those services that are not compensated by Medicare, Medicaid or any other third party payer. In summary, these 13 hospitals alone provided over 6.7 million outpatient department/emergency room visits, of which over 3.2 million (or 45%) were uncompensated.

Finally, Table 4 provides nearly 50 examples of the kinds of additional -- often unfunded -- services provided by these essential providers.

In the absence of system-wide health reform or universal coverage, both this extraordinarily high volume of uncompensated care, and these dozens of unfunded community-wide services, can only be funded through the kind of institutionalized "cost shifting" represented by Medicare DSH and medical education payments. In fact, because there are so few other funding sources now available for these services, it is actually possible to quantify what the loss of a significant part of this funding would mean to the communities served by these hospitals.

In 1993, for example, an as-yet uncompleted survey of NAPH members has preliminary found that just 48 NAPH member hospitals collected over $210 million in Medicare DSH payments, and nearly $270 million in direct and indirect medical education payments. If DSH payments were reduced by half and GME payments by approximately 40%, as some have proposed, this $480 million in essential support would shrink to approximately $260 million. Since there are equal (if not greater) pressures on Medicaid and direct local subsidies -- the other two primary sources of support for safety net health systems -- no other sources of funding are likely to be available to make up this loss of $260 million. The result could be dramatic in many communities, when you consider that at just these 48 hospitals, $260 million is currently sufficient to finance:

- Over 3 million uncompensated outpatient or emergency room visits,

- 100% of the cost of all of the 24 hour poison control, high risk pregnancy, substance abuse, rape crisis, mental health, tuberculosis, immunization, transportation and environmental crisis response services provided by these 48 hospitals, or

- All of the standby costs of the nearly 30 Level I trauma centers operated by these 48 hospitals (of which several are the only such trauma centers in their entire urban areas).

While Americans clearly spoke in November about their concerns with runaway government spending and programs, it is important that we ask the right question. We believe that the right question is not "how rapidly can we reduce all governmental spending and programs", but rather "how best can we determine what is the most appropriate role for government" in an era of limited resources? What are the essential services that government must continue to support or provide? Can we really afford to jeopardize any of these essential health services in our nation's metropolitan areas today? Is it realistic to expect them to be absorbed by the rest of the health system or funded or provided by "volunteers"? NAPH sincerely hopes that the answer to these questions in 1995, as it has been in the past, is an emphatic and bipartisan "NO".

In conclusion, I would like to call your attention to two additional areas of concern to NAPH in the current environment: managed care, and the ongoing need for infrastructure development by both urban and rural essential providers.

With respect to managed care, NAPH is concerned that the headlong rush to enroll millions and millions of Medicare and Medicaid recipients in managed care organizations could also be detrimental to patients and jeopardize many of the essential community-wide services provided by safety net health systems. We are not opposed to the concept of managed care itself. Indeed, we agree that managed care does have the potential to generate at least some initial savings for payers, and could result in improved access for low income and elderly patients to preventive and primary care services. The key, however, is to make sure that managed care is done right. It is imperative that sound, effective systems and networks are both available and accessible to enrollees before leaping into mass enrollment. Otherwise, there is a substantial risk that responsible, well-managed plans and providers will not be ready; that marketing, enrollment and discrimination abuses will occur; and that essential providers and systems will not be given an opportunity to participate on a level playing field with aggressive private organizations, resulting in substantial erosion of access and services for the millions of individuals and hundreds of communities who must continue to rely on these systems. These concerns are not abstract -- we have seen them played out in states like Tennessee, Florida, Arizona and California, and in other areas where premature efforts have been made to push massive numbers of people into managed care plans. A number of potential safeguards and solutions were also discussed extensively during the health reform debate last year, including the unanimous bipartisan vote of this subcommittee to include substantial protections for essential community providers. NAPH simply suggests that these concerns -- and these safeguards -- continue to be before you this year as you debate the potential broadening of Medicare managed care activities.

Finally, I would like to add a few words about the continuing need for federal support for infrastructure development and renovation by essential providers in both urban and rural underserved areas.

Such safety net hospitals face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A 1993 NAPH study estimated that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a Federal capital financing initiative is clearly needed. For the last three years, NAPH has assisted with the drafting of a new urban-rural capital financing initiative that was introduced by Representative Pete Stark in the House, and by Senators Thomas Daschle, Max Baucus and John Breaux in the Senate. Significant portions of this legislation were adopted in both Democratic and Republican versions of health reform legislation last year, including parts of the proposal that rely on private marketplace solutions such as loan guarantees to make capital available at very little additional cost to the Federal government. We strongly urge your continued consideration of these proposals this year.

I would be happy to answer any questions you may have at this time.

TABLE 1

GROSS REVENUES FOR NAPH MEMBER HOSPITALS

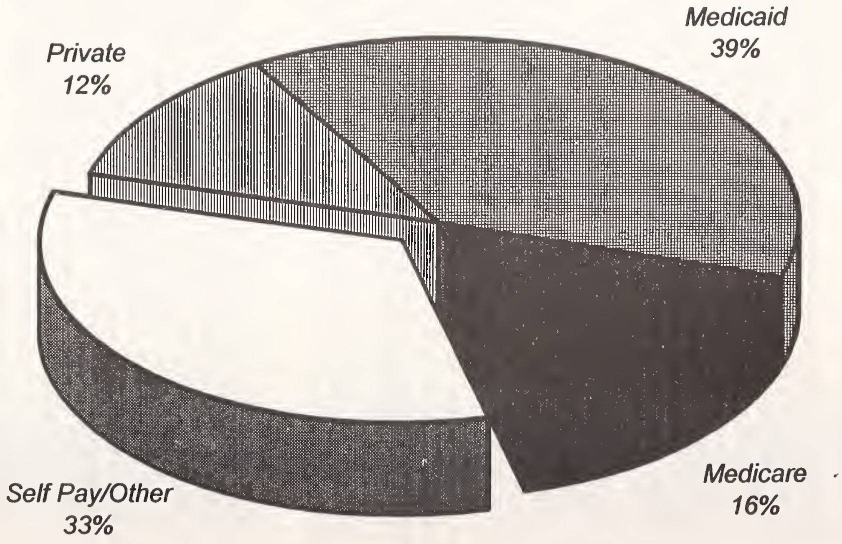


TABLE 2

OUTPATIENT VISITS BY PAYER SOURCE

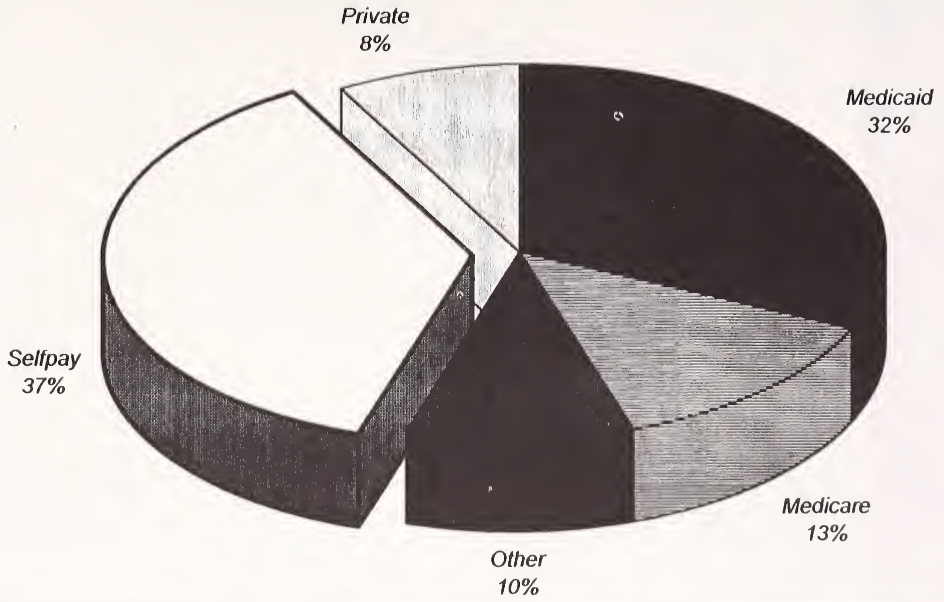


TABLE 3

Hospital Name	Uncompensated Visits	Total Outpatient/Emergency Room Visits	Percent of Visits Uncompensated
Harris County Hospital District	436,708	659,112	66%
Grady Memorial Hospital	569,084	864,733	66%
Cook County Hospital	398,570	691,465	58%
LAC+USC Medical Center	357,602	644,453	55%
Kings County Hospital	273,399	857,878	32%
Elmhurst Hospital	203,957	459,837	44%
Harbor-UCLA Medical Center	182,704	332,030	55%
Lincoln Medical & Mental Health	176,517	519,167	34%
Univ. of Texas Medical Branch Hospital	171,408	362,816	47%
Denver General Hospital	150,015	423,971	35%
Bellevue Hospital	139,490	458,202	35%
Medical Center at New Orleans	117,080	358,406	33%
Kern Medical Center	30,189	104,846	29%
TOTAL	3,206,723	6,736,916	45%

TABLE 4

Uncompensated Services Provided by Safety Net Hospitals

- Financial counselors
- Social workers
- Discharge planning
- Additional security for urban providers
- Translators/interpreters
- Financing assistance
- Prison health services
- Special services for AIDS patients
- Injury prevention/safety
- Smoking cessation
- Substance abuse diagnosis and treatment
- Nutrition assessment
- Nutrition counseling
- Child care for children of patients
- Transportation services
- Longer LOS and extra service for inpatients with secondary diagnosis of alcoholism/drug abuse
- Additional services for cocaine-exposed neonates
- Screening/preventative care (e.g. for lead paint poisoning, hypertension, diabetes, vision, hearing)
- Outreach
- School-based services
- Management of patients at risk
- Family planning
- Sex education
- Sanitation
- Case management for elderly
- Geriatric assessment teams
- Extra services/dental, vision, hearing
- Caregivers respite and family support
- Mobile services for homeless, homebound
- Communication services for patients without phones
- Patient advocates
- Legal assistance
- Chronic disease management for the disabled
- Medication management
- Rehabilitation
- Assistance obtaining housing
- Home health care
- OPD pharmacy services
- Day care for disabled adults/children
- Meals (emergency department/home)
- Special vocational education and rehabilitation
- Private, negative pressure rooms with appropriate ventilation for TB patients
- Trauma, burn care, neonatal intensive care and other tertiary services on 24-hour standby basis
- Abused/neglected children services
- Long-term care for boarder babies
- Parenting classes
- Birth centers
- Coordinated volunteer services
- Specialized clinics
- Patient education centers
- Money management/life skills training
- Cultural sensitivity training for physicians and other staff

Chairman THOMAS. Thank you very much, Mr. Gage, for your testimony.

Dr. Ebert.

STATEMENT OF PAUL A. EBERT, M.D., DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. EBERT. Thank you very much, Mr. Chairman. I am Paul A. Ebert, director of the American College of Surgeons. Surgeons always get invited to these hearings I think because we are one of the few groups, I believe, that has actually sustained over the last 8 years an absolute reduction somewhat in the fees that they have been paid under the Medicare program.

Now, we recognize that if you are going to have to enact further massive Medicare cuts, and if they are earmarked for deficit reduction rather than some type of alteration or improvement in a program, it is going to have some major effect on the infrastructure of the program.

This morning, I would like to just ad-lib some of this, because earlier comments were made that in the fee-for-service programs the volume of procedures provided, in general, increased. I wish that the people who mentioned that might have separated procedures from operations, because the college was one of the first groups that supported the Medicare volume performance standard.

We did this on the concept that there probably should be more, rather than fewer. Also, if you were going to have the profession actively involved in attempts to reduce costs, why the best way to do that was to try to get the reasonably sized professional organizations to have some impact on their own constituencies, because, as all of you know, with over 600,000 doctors in the United States, the similarities between surgeons and other individuals practicing medicine is not always as close as one might have anticipated.

Now, I sat in this room and heard that surgeons, since they were reduced the most in the OBRA legislation in absolute amounts, would be the ones that would increase volume the most, and that certainly has not proven to be true as we have come in under our MVPS over the last 4 years, at least to some degree.

I think this has been somewhat surprising to many. But, I just say in response to the comments that were made this morning, that this is a long-term program. I think the MVPS or expenditure target concept, since it does establish some predictability of government spending, is probably one of the few programs that the population of physicians is now finally starting to understand. We certainly hear in our own community more and more about it, and I think there will be efforts made to improve participation, and this should be recognized rather than to going back to a single standard, which I don't think would have the same impact.

Now, the college has strongly supported freedom of choice for the patient, and I think that the Medicare patient deserves the opportunity to go where they receive the best care. I also note in response to the comment that was made this morning, and I don't know if we have the data to show it in the Medicare system, that, very clearly, if you go into some type of managed cost operation, you go in usually at the time you are feeling well, and if you develop some serious type of illness, then you decide to go to some major medical center. Many times these medical centers are associated with the managed cost program, many times they are not, but the patients then drop out and, in a sense, the government pays twice—once for the lesser, higher priced services, and then more for the true illness when the patient requires this.

Now, we made some critical comments in our written testimony regarding the administrative components of the Medicare system. I would like to at least go on record and say that it is probably by far the worst system that is out there, although I think the MTS program is in the correct direction.

The biggest problem that occurs to surgeons has been that you get different sets of standards and requirements for admissions to hospitals and approval for operations across the country. Reducing the total number of carriers and at least the information disbursement programs that MTS has done so far has certainly decreased the amount of correspondence, and the many complaints we have had.

However, any way you look at it, it is still a sixties program and there are many areas, especially in utilization review and quality assurance, where the college has supported individual doctor profiling and the dissemination of other information that could be obtained, both to educate and to help reduce costs. We are not at the current time, I don't believe, obtaining the full benefits that we might from these capabilities.

I would just like to conclude on the administrative and regulatory comments again to say, you hear many things and many of you ask questions regarding a resource-based relative value scale that was created in 1989. I think it is fair to say it is reasonably refined at the present time. Mechanisms are in place where adjustments have been made, and I would say reasonably well. New technology and new procedures, new tests and so forth, have mechanisms through which they can obtain their code and their valuation.

As you probably are aware, there are 7,000 surgical codes in the RBRVS and in the CPT booklet of the AMA which is used for coding. We would hate to see that structure reexamined. Money is being spent by HCFA at the present time to reexamine the system to see if what was done in 1989 is correct.

Last year, money was approved to figure out how to look at practice cost as another component of the system. I think the college would certainly support the concept of establishing a single payment level. Use the payment schedule or whatever you wish to call it, but let's quit examining it each day. A doctor in his office doesn't have the foggiest idea that he gets paid for three components of his fee. He only understands the amount that comes in. And, consequently, I don't know why we spent millions to look at various components when, basically speaking, we are buying a single service.

We thank you very much, Mr. Chairman, for the opportunity to comment and we would be glad to work with you if at all possible.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the

SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS

presented by
Paul A. Ebert, MD, FACS

RE: Budget Reduction and the Medicare Program

February 6, 1995

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. On behalf of the more than 60,000 Fellows of the College, I am pleased to share our views with you about the Medicare program and the budget.

Budget Reduction and Medicare

Mr. Chairman, we recognize that your subcommittee and the new Congress face an especially difficult task in seeking to balance the health care needs of older Americans with the enormous pressures confronting you to constrain the ever-increasing growth of the federal budget. We realize that all citizens will be called upon to make some further sacrifices if any efforts to deal with the deficit problem are to succeed. But, we also hope that you will proceed with your review of the program in a most deliberate manner so that the public will fully understand the implications that any budget reduction plan may hold for the Medicare program and its beneficiaries.

On several occasions during the last two years, we appeared before this subcommittee to express our concerns about President Clinton's health system reform plan, which would have been financed largely by massive cuts in the Medicare program. We still believe that dramatic Medicare cuts of the magnitude proposed by the Administration--consisting almost entirely of major payment reductions to those who now provide services to beneficiaries--would seriously undermine continued support for the program. In particular, the disparity in payment levels for surgical services provided to Medicare patients compared with private plans in some parts of the country has widened dramatically in recent years. This is because in several previous budget bills, Congress has already made very significant and, in many instances, absolute payment reductions for the surgical services needed by older Americans. These are real payment reductions for many operations, not just reductions in the rate of increase in the fees for those services. We believe that further massive Medicare cuts--especially if they are earmarked for deficit reduction rather than health reform--cannot be realistically achieved without potential disruption to the infrastructure that now serves the health care needs of millions of older and disabled Americans.

Balanced Approach of Incentives for Providers and Beneficiaries

In addition to our concerns about the magnitude of possible Medicare budget cuts, we are concerned about the underlying design of any budget control plan. The College believes that cost control under Medicare or any other federal program should, insofar as possible, rely on incentives rather than on heavy-handed or formula-driven approaches that simply seek to "ratchet down" payment rates in arbitrary ways. Such incentives should include both performance-based methods and marketplace pressures to make both patients and providers more aware of the costs of medical care. The American College of Surgeons, as you know, has long been a supporter of policy devices like expenditure targets (in the form of Medicare volume performance standards) that provide incentives to meet spending targets for surgical and other physicians' services. These targets also involve physicians and physicians' organizations in helping to address growth in the cost and volume of services provided to Medicare patients.

We think Congress may want to consider expanding the concept of expenditure targets beyond Medicare physicians' services and applying it to other service categories. Such performance-based approaches are consistent with the notion of using incentives to involve service providers in addressing volume-related issues. Moreover, expenditure targets are explicit, are set in advance, and are clear for all to see before they are applied. This means that Medicare beneficiaries, health care providers, and policymakers would all know "up front" the reasonable level of federal funding needed to address the health care requirements of older and disabled Americans covered by the program.

Devices like expenditure targets make it possible for the government to establish some predictability to spending increases, while transferring the risk for failing to meet reasonable spending goals to those who influence the volume of health services actually provided. Surgeons in the U.S. who treat Medicare patients have consistently met these goals by keeping spending for their services under Medicare's annual targets.

But, expenditure targets are also important for another reason--namely, they can be used to address spending issues while still preserving beneficiary choice of physician, hospital, or other suppliers of services. We believe that the issue of patient choice is especially important for many Medicare patients. The College supports the continuing ability of individuals and families, including the elderly, to meet their health care needs through a variety of arrangements. Indeed, we would be very concerned if Congress proposed to redesign Medicare so that beneficiary choice of health plans is limited to only one kind of arrangement. Today, Medicare patients can choose the traditional program, which fully guarantees patient choice of physician, or they may enroll in a Medicare managed care plan if one is offered in their area. Perhaps Congress should consider new ways to broaden the choice of Medicare plans available in different parts of the country, but the final decision about which plan is best for older Americans should be left up to them.

Benefit Design Changes

Part of your efforts to examine Medicare should include a reexamination of the beneficiaries' responsibilities relating to the overall costs of the program. For example, beneficiaries pay only about one-quarter of the premium costs of the Supplemental Medical Insurance (SMI), or Part B, portion of Medicare; the balance is financed from general revenues. However, these subsidies, which are paid directly from the treasury, are provided on behalf of all enrollees 65 years of age and over without regard to their income or their ability to pay. It seems odd that some of the wealthiest people in America, who are covered by the program, are not asked to pay something more toward the costs of supplemental coverage, or at least to have some or all of the government's currently tax-free contribution counted as income to them.

Home health and skilled nursing facility services are among the fastest growing service sectors in the Medicare program. Currently, copayments are not required from enrollees for home health benefits, while copayments for skilled nursing facility services are required from enrollees for each day after the first 20 days of care. In 1994, the Congressional Budget Office (CBO) described a number of options for reducing the deficit, including a proposal to require patient coinsurance payments equal to 20 percent of the projected average cost for each home health visit and each skilled nursing facility day. CBO also noted that Medicare currently pays 100 percent of an approved fee schedule for clinical laboratory services--another rapidly growing part of Medicare. Beneficiaries currently pay a coinsurance of 20 percent for most Part B services, and a coinsurance did apply to laboratory services before July 1984. Establishing coinsurance requirements for home health benefits and for clinical lab services may be in order and, according to CBO, could yield appreciable savings for the program.

The Part B deductible is fixed by current law at $100 per year. This deductible is the amount of expenses for covered Part B services that beneficiaries must incur annually before SMI benefits are paid. Unlike the hospital insurance, or Part A, deductible, the Part B deductible is not "indexed" or adjusted annually to reflect changes in the costs of covered services. Indeed, the Part B deductible was last adjusted by Congress in 1991, when it was raised from $75 to $100. Perhaps Congress should adjust the Part B deductible upward beginning in 1996, or else adopt some sort of scheduled adjustment for future years that will set the amount more closely in line with increases in the costs of Part B services.

Administrative and Regulatory Changes

Congress should consider ways to improve the administration of the Medicare program and take other steps to reduce regulatory burdens that impose unnecessary costs on taxpayers, and to reduce paperwork and other administrative burdens on patients and providers of health care. For example, the present system used by Medicare to administer the program is nearly 30 years old, and still consists of an archaic, inefficient, and fragmented system of contractors that perform claims administration and other functions. While Medicare program managers have initiated a number of steps to enhance the efficiency of some aspects of the program, such as implementing the so-called Medicare Transaction System (MTS), Congress should explore other steps to streamline the administration of the program. Substantial improvements in data processing and information technologies should make it possible to update an administrative system developed for the marketplace of the 1960s by applying 1995 management techniques.

Finally, the regulatory framework of the Medicare program should be thoroughly reexamined and overhauled. Over the years, Medicare has developed incredibly complex administered pricing schemes for determining payment amounts for services covered by the program. More recently, the government has spent millions upon millions of dollars conducting studies, holding meetings, and issuing lengthy proposed and final rules to develop three separate components to payments for the more than 7,000 individual surgical, medical, and diagnostic services that make up the Medicare fee schedule. Now, the government is going to start this process all over again to make sure its previous regulatory scheme is "up-to-date."

Last year, Congress ordered Medicare to spend even more money to try to determine the precise relative values that should be recognized under the fee schedule as the overhead (or practice expense) component for each and every physician service. This means yet further micro-management of an already overly-cumbersome approach to setting national Medicare prices. No pretense is made that this change will save any money; in fact, the law specifies that budget neutrality should be observed in implementing the proposal. Certainly, we believe there are some less intrusive, less complicated, less disruptive, and, most assuredly, less costly ways to determine what Medicare will pay for physicians' services.

Thank you again, Mr. Chairman, for this opportunity to express our views. I would be happy to answer any questions that you or the other members of the subcommittee may have.

Chairman THOMAS. Thank you very much, Doctor, for your testimony.

Mr. Christensen, you may inquire.

Mr. CHRISTENSEN. Dr. Ebert, you mentioned the Medicare volume performance standard and the fact that surgeons seem to have done better than the other physicians in hitting those targets.

What differences are there and why haven't other physicians done as well as the surgeons? Do you have any input on that?

Dr. EBERT. Well, I think we took it somewhat as an insult to our integrity when individuals said we would increase service volume just because our payment amounts were decreased. We worked very closely with the various surgical specialty societies and put out a fair amount of publicity, meetings and so forth, and said that, basically, operations ought to be recommended based on the indications that you normally learned.

I think most people did not think that an expenditure target or MVPS program would go through. We were under the belief that you could never have an RBRVS without an MVPS or something to control volume. I still hear the volume issue being discussed here this morning, and for almost every type of service we are seeing increases. I think other groups are getting more active in it now and more concerned about it. That is why I say that I think this is a long-term program, and that it may need to be broken down even into smaller numbers.

Mr. CHRISTENSEN. Dr. Lewers, I wanted to ask you, could you discuss in greater detail the regulatory and administrative burdens that you and other doctors face under the existing program? Also, could you expand on how some of those regulations could be streamlined and made more consumer friendly.

Dr. LEWERS. Two most onerous and regulatory changes that have occurred in a physician's office are those that have been brought about by CLIA, the Clinical Lab Improvement Act, and also the issue of the OSHA regulations. In my office alone, when those two came into being, the cost of implementation, the cost of running my office with two physicians went to close to $10,000; simply the cost of changing and buying all equipment and things of this nature.

The documentation that is necessary in these areas is very onerous. It is not to say that some of the study and some of the material that they have brought forth is not needed. It is. But not to the degree that it has been brought forth. We could provide you more information on that if you would like.

The issue of paperwork is simply the issue of having to sit down and get preclearance on issues and things of this nature. It is now estimated that physicians spend 25 percent of their time doing paperwork in relation to their practice, time that we could be utilizing serving our patients.

In brief, these are two major areas. The issue of OSHA and CLIA are very burdensome on the back of physicians, and we would love to see some changes occur.

Mr. CHRISTENSEN. Well, I know that I concur in that sentiment. I wanted to just briefly touch on Mr. Gage's testimony. My eyes aren't very good, but I could see a couple of things on the fourth chart that was up there earlier. Mr. Gage, with all due respect, I am glad that we are not funding cultural sensitivity and money management training at the public hospitals, because I don't believe that is the role of the Federal Government to be funding those kinds of programs.

Mr. GAGE. May I respond?

Mr. CHRISTENSEN. Yes, you may.

Mr. GAGE. I think that in a general sense, I might agree with you in the abstract about simply going out into the world and funding services like this.

The problem is, when you are in a public hospital in an inner city, you are often faced with a real, live patient who may have no home to go to, who may have inadequate coping skills to be able to even begin to address the way to get a prescription filled, or to have access to adequate nutrition, or to be able to find someone who speaks that person's language to help care for him outside the hospital. Some of our hospitals have translators in 17 and 18 different languages. You are pretty much required to provide those services before you send that patient back out into the streets whether or not anyone is paying for them. It is not as if the hospitals have asked for this role. They are now performing this role.

This patient—if he doesn't get or she doesn't get these services from this institution—is going to need to find these services somewhere. When you just read them up on a board like that, they may sound as if perhaps they are unnecessary in general or inappropriate for the health system, but I can assure you when you are sitting there with 20 or 30 people in the room waiting to be discharged after being treated for often very, very serious illnesses, you are trying to find ways to help them survive and not become a further economic burden on the health care system.

Mr. CHRISTENSEN. Well, I think your testimony goes to the point that this committee and the Congress as a whole are trying to totally transform the welfare system. One of the items that you have outlined on the chart goes to a bigger picture that I think this committee has been challenged with in terms of transforming and changing the welfare state into an opportunity state.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Mr. Gage, continuing in the discussion on the charts, on the first chart, you had a category which was self or other funded at 33 percent, I recall, and Medicare was 16 percent. Medicaid was 39 percent. What is included in the other portion of the 33 percent? I understand the self, and I guess I would ask you what portion of the 33 is self and what is other, and what portion that would be?

Mr. GAGE. Well, other is actually a relatively small proportion, but, for example, there are certain other sources of funding. For example, some is provided through their States as federally qualified health centers, which many of our hospitals actually have or have that designation.

Chairman THOMAS. I was wondering if any of that was State or local funding that came in under the other.

Mr. GAGE. Yes, that chart showed gross revenues as "self or other." A self-funded patient whose services are provided by a public hospital has to be paid for in some fashion. If you looked at net receipts, for example, Medicare goes from 16 percent to close to 20 percent because Medicare is getting some of that cost shifted to them.

Similarly, Medicaid pays some of these costs, particularly in those States that have used disproportionate share funding, but the bulk of the 33 percent would actually be funded by direct State or local subsidies, by counties.

Chairman THOMAS. OK. So government at the State and local level would be funding it, because I noticed that you included my county hospital operation and although the numbers didn't meet the volume in the urban areas, I thought it was also interesting that your top hospital had, I believe, a 66-percent uncompensated care figure whereas for Kern County Medical Center it was 29-percent uncompensated. I would ask you, does uncompensated mean unfunded?

Mr. GAGE. Uncompensated means that that patient didn't have a third-party payer, didn't have Medicaid, didn't have Medicare, and that the funding had to come from some other source, but clearly there is no such thing as a free lunch.

Funding was necessary and it is this patchwork combination of cost shifting from Medicare and Medicaid, as well as direct—in the case of California, county subsidies, or State subsidies that have come about as a result of proposition 13.

Chairman THOMAS. So what you saw, for example, in Kern County Medical Center with a 29-percent uncompensated——

Mr. GAGE. Yes.

Chairman THOMAS [continuing]. You get probably more local moneys, county or State moneys into that formula than the 66-percent uncompensated.

Mr. GAGE. Probably in California, counties would be paying for a higher proportion of the 29 percent than at a hospital which had 66-percent unfunded.

Chairman THOMAS. No, not unfunded, uncompensated. I thought we established that unfunded was not the same as uncompensated.

Mr. GAGE. Right.

Chairman THOMAS. So there is money going into the program. It is just that you don't identify it from those particular sources. Would this be general funding for the operation of the hospital, allocations from a funding source without tying it to the individual patient?

Mr. GAGE. That is right. It would be local property taxes, for example. The 66 percent I think was the Harris County Hospital District, which is in Houston, and they raise direct local property taxes to pay for the needed subsidy.

Chairman THOMAS. OK. I just want to establish that uncompensated doesn't mean that people haven't figured out a way to pay for it. That is a larger question that we have to deal with.

In terms of the AMA and the College of Surgeons, you understand the schizophrenia we are in in terms of trying to create a formula for paying under the old, as you indicated, Dr. Ebert, fee-for-service structure where we are still looking at ways in which we can make changes to deal with the changes that have occurred in the private sector. What we will be asking of you folk, is all of the help that we can get from you in terms of simplifying models that we use to emulate or try to reflect the private sector without a high degree of complexity which eats up costs, but which gives us a relative reflection on what is going on out there with the understanding that we are going to pass through that process hopefully within a 3- to 5-year period.

And it is extremely frustrating in dealing with the structure which needs to change fundamentally, but which also has to change incrementally. Dr. Lewers, I don't know if you referred to it. I went through your written testimony in general in terms of the specifics we are looking at, but in terms of outcomes, some of the research that is going on now, are you folks looking at this area, one, in terms of a clear maximization of resources that you have available? Are you focusing on this at all in any area to assist in the question of fraud and abuse? Is that an area that we can utilize these outcomes and tests?

Dr. LEWERS. Yes, outcomes certainly is a very broad term and, yes, we are focusing on it in all areas, other than just fraud and abuse. Basically, the AMA has a zero tolerance for fraud and abuse. We have been working with the Inspector General. We have been working with Justice on this, and we hope to continue; it is a very active part of our program and one that we will continue to work with.

The whole process of outcomes, of practice parameters, are areas that we certainly need to concentrate on. We have one section of our staff that is working completely in that area. We are concentrating on this and I think you will see some reports coming from us on those areas.

Chairman THOMAS. Thank you very much.

Dr. Ebert, I agree that the cynicism in the last round of structuring for surgeons in terms of assuming that you would make up in volume what you weren't going to get in each procedure was not properly founded, and I am pleased to know that you astounded the experts by not carrying out their preconceived notions for behavior.

Having said that, it still doesn't mean that the system was necessarily right to begin with and that perhaps the targets that were anticipated were not as realistic as they should have been. So within the questionable realisticness of the structure, I still want to compliment you folks for not living up to the behavior that a lot of folks thought you were going to. But we have got to get the structure right. I want to thank the panel very much for its testimony. I would ask panel number four to come forward.

As we welcome our last panel today, I would say that all of the panelists' written testimony will be made a part of the record without objection, and would ask that you proceed in whichever fashion you wish for your 5 minutes, and this panel consists of Richard Doherty, National Association for Medical Equipment Services; Dr. David Sundwall, president of the American Clinical Laboratory Association; Dr. Paul Willging, executive vice president, American Health Care Association; Mary Suther, president of the Visiting Nurse Association of Texas; and Eugene Lehrmann, president of the American Association of Retired Persons. I guess we should go with beauty before age, Mr. Lehrmann, so we will start with Mr. Doherty, if you will begin, you have 5 minutes.

STATEMENT OF RICHARD DOHERTY, PRESIDENT, COMPREHENSIVE HOME HEALTH CO., BOSTON, MASS.; ON BEHALF OF THE NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES AND THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. DOHERTY. Thank you, Mr. Chairman. Good morning, Mr. Chairman, members of the committee, my name is Rick Doherty, and I am pleased to be here on behalf of the National Association for Medical Equipment Services, NAMES. I am the president of Comprehensive Home Health Co., a provider of home health equipment in eastern Massachusetts. The testimony I am giving today was done in collaboration with HIMA, the Health Industry Manufacturers Association.

We are pleased to have the opportunity to address the committee on the issue of growth in Medicare expenditures. However, I would like to take a moment to address the issue of fraud and abuse, since the hearing has dealt with that to such a degree.

Mr. Chairman, you said that there are people who game the system and you are absolutely correct. The people that game the system, I would like to point out, however, primarily are people that are on the fringe of the industry, they are not what we consider legitimate providers. They are people that jump in and out and get provider numbers, usually focusing around one or two products and services. They make a lot of money and they are gone again.

We, the legitimate industry, have been advocating and will continue to advocate that there be restrictions placed on the front end preventing people from getting into the system in the first place. We advocate for certification, standardization, even licensure, potentially including onsite inspections of providers to ensure that they are legitimate. We think that although these are not the only steps necessary to curb fraud and abuse, they would go a long way to get the unethical providers out of the industry.

We were asked by this committee to provide you with solutions to the problem with the growth in Medicare. We agree that there has been growth in Medicare expenditures for home medical care equipment services. However, we submit that this is not the problem, but a solution in its own.

First, it is important to state the total Medicare outlays for home medical equipment are a combination of the cost of equipment services and the rate of utilization.

Second, the trend in the per-unit cost for home medical equipment services has been steadily downward for the past decade, even though Medicare expenditures have gone up, which is directly a function of utilization.

Third, many people have a misunderstanding of our industry and the vital cost-effective role that we can play in helping to deliver greater value to the Medicare program.

There are a number of factors that have contributed to the recent growth of home care and specifically home medical equipment services. First, our Nation's elderly population is increasing rapidly from 30.5 million Americans in 1984 over 65 to 37 million Americans this year, a 25-percent increase. Even more significant is the fact that the fastest growing segment of our population is a group of Medicare-eligible citizens over the age of 80, because this is the group that uses the most home medical equipment services.

Technology previously limited to use in institutions is now being used more readily in the home. It is not necessarily new technology. It is just that the technology is now being used at a less expensive, more effective means in many cases in the home.

While traditional postacute capability remains in place and available, an increasing array of new home care services and equipment is available for postacute and chronic patients who in prior years have required more costly hospitalization.

A 1991 Lewin ICF study examined reimbursement charges for home medical equipment and concluded that while total outlays had increased as a result of demographic changes, the reimbursement per item had decreased as a result of the implementation of the congressionally mandated six point plan in 1989.

The Lewin study further compared the cost of home care using home medical equipment versus hospital care for three diagnoses, hip fractures, amyotrophic lateral sclerosis with pneumonia, more commonly known as Lou Gehrig's disease, and chronic obstructive pulmonary disease. We found that home care using home medical equipment resulted in cost savings of between $300 and $2,300 per patient per episode. When multiplied by the prevalence of each illness, the potential annual savings per year was estimated at $575 million for hip fractures alone.

Again, I submit to you that the growth in Medicare expenditures for home care services is our solution and not the problem, and that that care can save our Nation's health financing system millions of dollars.

The industry recognizes the legitimate interest Congress has in carefully examining all Medicare benefits to ensure that the use of trust fund and taxpayer moneys is as economical and efficient as possible, consistent with the delivery of high-quality services to beneficiaries.

However, despite the critical role which home care plays, home medical equipment continues to be the recipient of budgetary reductions to such a severe level that it creates concern that the ultimate effect may be well the dismantling of the entire home medical equipment service industry as we know it.

We must also keep in mind that the home medical equipment outlays represent only approximately 2 percent of the Medicare expenditures. The solution is simple. The growth in home care expenditures is saving American people money. We want to work with you to assure that patients' needs are met in the most efficient way possible.

In an era of increasing cost consciousness and concern about the long-term care of our Nation's elderly and people with disabilities, it makes good policy sense to preserve and foster the very benefit that provides home care services in a cost-effective and compassionate fashion.

Thank you, Mr. Chairman.

[The prepared statement follows:]

NAMES
National Association for
Medical Equipment Services

Testimony
of
the
National Association for Medical Equipment Services
on
Growth in Medicare Expenditures

Hearing
of
Monday, February 6, 1995

Before
the
House Ways and Means
Subcommittee on Health

Mr. Chair and Members of the Committee, my name is Rick Doherty. My company, Comprehensive Home Health Company, serves individuals residing in the metropolitan Boston Area. I have 15 years experience as a provider of home medical equipment (HME) services. Currently, I also serve on the Board of Directors and am a former Chair of the National Association for Medical Equipment Services (NAMES). I am pleased to appear before you today to testify on behalf of HME providers across the country and to address this Committee on the issue of the growth in Medicare expenditures. The testimony I am presenting today was prepared in collaboration with the Health Industry Manufacturers Association (HIMA).

NAMES members comprise over 2,000 HME companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to patients in their homes. According to physician prescription, HME providers furnish an extremely wide array of HME and related services to patients in their home, ranging from more "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and specialized rehabilitation equipment customized for the unique needs of people with disabilities. Many of these patients are Medicare beneficiaries.

The Health Industry Manufacturers Association (HIMA) is a Washington, D.C.-based national trade association representing more than 700 manufacturers of medical devices, diagnostic products and health information systems. Approximately one-quarter of HIMA member companies have annual sales of less than $2 million. HIMA's members manufacture more than 90 percent of the nearly $40 billion of health care technology products purchased annually in the United States.

Mr. Chair, Members of the Subcommittee, we are all here today to examine the problems with growth in Medicare expenditures. We were asked by this Committee to provide you with solutions to this problem. We agree that there has been growth in Medicare expenditures for home care services. However, we submit that this is not the problem, but a solution in its own.

As the Committee begins its examination of areas of significant growth in Medicare costs, we urge you to explore the important role which home care has played in helping to reduce costs and to provide quality cost-effective care to millions of Medicare patients.

First, it is important to restate that total Medicare outlays for home care are a combination of the cost of equipment services and the rate of utilization.

Second, the trend in the per unit cost for HME services has been steadily downward for the past decade, even though Medicare expenditures have gone up, which is directly a function of utilization.

Third, many people have a misunderstanding of our industry and the vital, cost-effective role that we can play in helping to deliver greater value to the Medicare program.

The growth in the Medicare program and the number of citizens eligible for Medicare presents a challenge for the government and for all Americans. The HME services industry has and will continue to play a vital role in the delivery of cost-effective quality care to Medicare beneficiaries.

Medicare Outlays

There are a number of factors that have contributed to the growth in recent years of home care and specifically HME services.

First, our nation's elderly population is increasing rapidly. In 1984, there were 30.5 million Americans over the age of 65 who were eligible for Medicare benefits. Medicare actuaries project that the number will grow this year to 37 million Americans, a 25% increase. Even more significant is the fact that the fastest growing segment of our population is the group of Medicare eligible citizens over the age of 80, because it is this group that has even more critical need for home medical care. The growth in the Medicare eligible population over the past decade provides a factual history to support the Lewin ICF prediction.

Technological advances also are making possible high levels of quality care in the home that, in prior years, was available only in institutions. As patients' needs have evolved, so too has home care technology. While traditional post-acute capability remains in place and available, an increasing array of new home care services and equipment is available to post-acute and chronic patients who, in prior years, would have required hospitalization.

The 1990 *Green Book*, published by the House Ways and Means Committee, projected that the baseline for HME services would be equal to $3.3 billion in 1995. However, the 1993 *Green Book* baseline projection for HME expenditures for 1995 has been decreased to $2.7 billion. Coupled with the fact that the growth in the number of disabled and elderly Medicare beneficiaries for Part B services increased by more than 14% over this same three year period, it would appear that our services are not growing fast enough to meet the growing number of beneficiaries. Actually, we would argue that the growth in expenditures has fallen behind the growth in Medicare beneficiaries.

Utilization

Currently, there are approximately 5,000 to 8,000 HME providers, about 11,000 home health agencies and some 1,200 freestanding hospices providing home care services to millions of Americans. Home care services come in many forms, from lifesaving equipment to specialized nursing care and financial management assistance for patients and their families. Provision of these services often can be more cost-effective than certain institutional care, while maintaining as high a level of quality of care as hospitals, nursing homes and other facilities.

A 1991 Lewin ICF study examined reimbursement charges for HME services and concluded that while total HME outlays had increased as a result of demographic changes, the reimbursement per HME items had decreased as a result of the implementation of the Congressionally-mandated Six-Point Plan implemented in 1989.

The Lewin study further compared the costs of home care using HME versus hospital care for three diagnoses: hip fractures, amyotrophic lateral sclerosis (ALS) with pneumonia, and chronic obstructive pulmonary disease (COPD). The study found that home care using HME resulted in cost savings of between $300 and $2,300 per patient episode. When multiplied by the prevalence of each illness, the potential annual savings per year was estimated at $575 million for hip fractures alone.

Recent studies also have found that a large majority of Americans believe that receiving treatment in the comfort of their own home when recuperating from an illness or injury would be vastly preferable to some form of institutional care. A 1991 American Association of Retired Persons (AARP) study found that nearly 3 out of 4 older Americans would rather provide care for a disabled, frail or elderly relative or friend at home, rather than have to admit that person to a nursing home. NAMES 1991 "Coming Home" study revealed identical results.

While total outlays for HME services have grown with the increase in the number of beneficiaries that are being cared for, the reimbursement amounts for these services have shrunk in recent years. Let me review briefly some of the history of Medicare reimbursement for HME services so that the Committee can appreciate the magnitude and frequency of the changes. In the past 5 years the HME services industry alone has been subject to extensive Medicare reductions including: $180 million in OBRA '89; $215 million in OBRA '90; and $950 million over 5 years in OBRA '93. These figures are significant when combined with the fact that HME outlays represent approximately only 2 percent of the total Medicare program expenditures and represent more than 3 times the industry's proportional share of reductions. Other reduction in the past decade include:

- 1985 Least Costly Systems Initiatives;
- 1986 Inflation Index Charges/Freeze;
- 1986 Concentrator Equivalency Limits/Freeze;
- 1986-1988 Gramm-Rudman-Hollings Cuts;
- 1987 Lowest Charge Levels/Concentrator;
- 1987 OBRA '87 mandated the establishment of fee schedules;
- 1988 Inherent Reasonableness/Freeze;
- 1989 OBRA '89 eliminated inflation updates for DME, reduced payments for seat-lift chairs and TENS by 15%, and directed that motorized wheelchairs be treated as routinely purchased items;

• 1989	Six-Point Plan;
• 1989	PRN Cuts;
• 1986-1990	Freezes;
• 1990	OBRA '90 established ceiling and floors to the HME fee schedules to make payments more uniform, prohibited suppliers from distributing completed or partially completed CMNs; and
• 1991-1993	CPI Cuts.

Cost Effectiveness

It is important to look at the costs associated with home care support for Medicare, but these statistics fail to tell the most important story about how home medical equipment providers are daily meeting the needs of Medicare patients throughout the country, and at the same time striving to find the most cost-effective methods of delivering care.

For example, two years ago a major health care clinic in the Midwest began a study of Medicare patients who had undergone hip replacement surgery to determine how they might reduce the overall cost of therapy and recovery from this procedure. An initial review of the records of patients over several years disclosed that the average hospital stay following the operation was 11 days, at a cost of more than a thousand dollars a day. Within a year, the health care clinic instituted a new program of aggressive therapy combined with an early patient discharge that had reduced the hospital stay to 5 days at a significant cost savings to Medicare and to the patient or the patient's insurance carrier.

The 1993 Los Angeles earthquake offers another dramatic illustration of the critical role that an HME services provider may be called upon to perform in an emergency. The shock of the quake disrupted electrical power and telephone service throughout the region. Within three hours, the locations of every patient whose medical care might have been disrupted were revealed, and vehicles with technicians and respiratory therapists were dispersed to deliver back-up equipment, oxygen and related supplies which helped keep the patients in their homes and out of hospital emergency rooms. This is just one example in many recent disaster stories like the recent earthquake in Japan, the Florida hurricane a few years ago and the flooding last year in the Midwest where HME suppliers went beyond the call of duty to ensure that their patients were spared physical, emotional and monetary harm.

Fraud and Abuse

The HME service industry takes seriously its mission to promote access to quality home medical equipment (HME) services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. From the first public allegations of abusive business practices in the HME services industry, the industry has worked assiduously with the Administration and Congress to help eliminate the few unethical suppliers who damage the reputation of an otherwise upstanding industry which helps make "homecomings" possible.

NAMES most visible legislative effort consisted of working during the 102nd Congress with Rep. Ben Cardin (D-MD), who introduced H.R. 2534, the "Ethics and Treatment of Home Medical Equipment Act of 1991." This legislation, which was co-sponsored by 112 Members of Congress, remains the most far-reaching of all subsequent HME bills introduced in Congress to date. Many provisions and concepts in H.R. 2534 were incorporated into legislation that passed the 102nd Congress in 1992, but were vetoed by President Bush. In the 103rd Congress, NAMES help Congress enact legislation, the Social Security Act Amendments of 1994, into law (H.R. 5252 & S. 1668) that incorporates many of the ethics provisions contained in H.R. 2534.

The HME services industry also worked very closely with the Health Care Financing Administration (HCFA) on its decision to establish four durable medical equipment regional carriers (DMERCs) that now process Medicare DME, prosthetics, orthotics and supplies (DMEPOS) claims exclusively. The four DMERCs were established primarily by HCFA to reduce fraud and abuse in the HME services industry.

NAMES has advocated for years that there must be stronger accreditation, certification and licensure requirements, potentially including on-site inspections. Despite the work of NAMES and HME suppliers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices. We urge this Committee to work with the HME services industry to create minimum industry standards and require accountability measures in order to obtain a supplier number from HCFA.

Solution

Again, I submit to you that the growth in Medicare expenditures for home care services is our solution and not the problem. The HME marketplace today reflects the growing number of patients as well as their needs and expectations for quality services. Home care using HME services and rehabilitation/assistive technology can ensure the continued provision of high quality health care in a setting that the vast majority of patients and their families prefer. And, that care can save our nation's health financing system millions of dollars.

NAMES and HIMA recognize the legitimate interest Congress has in carefully examining all Medicare benefits to ensure that the use of trust fund and taxpayer monies is as economical and efficient as possible consistent with the delivery of high quality services to beneficiaries. Both organizations are prepared to work with Congress to assure that patient needs are met in the most efficient way possible.

However, despite the critical role which home care plays in allowing people to be discharged sooner from an institution and permitting people with disabilities to lead productive lives away from an institution, HME continues to be the recipient of budgetary reductions to such a severe level that I am concerned the ultimate effect may well be the dismantling of the entire HME services industry.

The solution is simple. There is a growth in home care expenditures and yet these expenditures are still saving the American people money. We must focus on consumers and ensure that beneficiaries are receiving quality care and the services they deserve. The HME services industry wants and needs minimum service standards and accountability measures. We want to work with all of you. In an era of increasing cost consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve and foster the very benefit that provides home care services in the most cost-effective and yet compassionate fashion.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Doherty.
Dr. Sundwall.

STATEMENT OF DAVID N. SUNDWALL, M.D., PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION

Dr. SUNDWALL. Thank you. My name is David Sundwall and I am president of the ACLA, the American Clinical Laboratory Association, and I am very pleased to be able to testify before you today. I will keep my remarks brief and submit our written comments for the record.

I want you to know I am a practicing physician, and have been for over 20 years. I see patients every week, and I know on a first-hand basis how absolutely essential laboratory work is in order to take care of patients well. I also understand, representing ACLA, the challenge you have before you and the importance of this hearing in addressing Medicare expenditures. I want you to know that ACLA is committed to insuring that laboratory services are used appropriately and in the most cost-efficient manner.

This afternoon I am just going to make five brief points. First of all about reimbursement, as all others have testified today, I can't resist telling you that laboratories really are currently in the midst of a 3-year reduction in their reimbursement, thanks to OBRA 1993. These provisions amounted to a cut of about $3.3 billion over 5 years, a reduction of about 14 percent. I also want to point out that unlike some of the other providers that have referred to reductions in their future rate of increases, the cuts I am talking about constitute actual reductions in the amounts received by our labs.

Second, ACLA believes that one of the most important ways to ensure appropriate utilization of laboratory services is by working closely with physicians. Doctors, after all, are the only ones who can order tests. To ensure that they understand the tests they are ordering and the impact of their decisions, ACLA is working to help them understand the costs to the Medicare program of the tests they are ordering.

We also believe that the development of clinical practice guidelines will promote proper use of clinical laboratory testing. We encourage Congress to continue their support for the Agency of Health Care Policy and Research in the Public Health Service and their development of clinical guidelines.

Third, standardization. ACLA strongly believes that if the rules applicable to clinical laboratory testing for Medicare were simplified and clarified, it would also promote appropriate use of laboratory testing. As the GAO noted in their testimony, individual carriers have great discretion in setting payment rules and policies. This is a special problem for our large national labs who deal in many States and therefore have to deal with several different carriers and their jurisdictions.

For example, ACLA and other medical specialty groups have been working with HCFA concerning so-called automated multichannel chemistry testing. These tests are subject to widely different policies, depending on which carrier is involved, which results in widespread confusion in the industry.

ACLA and other groups recently submitted comments to HCFA on their proposal for new policies that would determine how these tests are paid for. Although we have some concerns about several features of the HCFA proposal, we are very pleased they have recognized the need for national standards with regard to such testing, and look forward to working with them to refine their policies.

In addition, ACLA also believes that administrative procedures could be further simplified and costs reduced if laboratories were permitted to bill through a single carrier rather than numerous different ones. This process would create more uniform interpretation of laboratory policy rules, and we hope the subcommittee will consider recommending such a consolidation of carrier responsibilities.

Fourth, we believe that appropriate utilization of laboratory testing would be helped by enactment of a direct billing mandate, a requirement that the laboratories performing the tests bill the patient or the insurer for those services. Data from a study done by the Center of Health Policy Studies strongly suggests that such a provision would lead to more cost conscious and efficient delivery of testing services, because direct billing precludes physicians from adding a markup to clinical laboratory testing that they do not themselves perform.

The study compared prices and utilization of testing services in States which require such direct billing and compared them with States where direct billing is not required. The analysis determined that direct billing reduced utilization and lowered health care costs overall. Even though Medicare already requires direct billing for their services, the same study found that even Medicare utilization dropped lower in States where direct billing was required. Apparently this is because physicians change their ordering patterns for all patients regardless of the payer.

And finally, my last point is that I—ACLA—must object to another proposal that has been made in the past and which we anticipate will be made again, the reinstituting of coinsurance for lab services. Coinsurance was eliminated in 1984 when the current fee schedule method, which set fees at 60 percent of then prevailing rates, was put in place. We have two objections.

First, coinsurance amounts to an additional cut in lab reimbursement inasmuch as we are still in the process of implementing the reductions required by OBRA 1993. Because of the amount, the coinsurance is often just a few dollars on each claim, the cost of billing this coinsurance is usually more than the amount that could be collected.

I am going to skip an example included in my written testimony, and will simply tell you that for a pap smear it would cost more to prepare and mail the letters to solicit the copayment than if we just ignored it.

The last point I want to make on coinsurance is that we do not believe it will affect utilization, and after all, that is what the purpose of this hearing is about. Laboratory services can only be ordered by physicians and thus both the OTA and the CBO have noted in separate studies that imposing a copayment obligation of Medicare beneficiaries does not curtail utilization.

I want to thank you for inviting us to testify today and I would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF
DAVID N. SUNDWALL, M.D., PRESIDENT
AMERICAN CLINICAL LABORATORY ASSOCIATION
TO THE HEALTH SUBCOMMITTEE
HOUSE COMMITTEE ON WAYS & MEANS

February 6, 1995

As the new President of the American Clinical Laboratory Association ("ACLA"), I am pleased to have this opportunity to introduce myself and to present ACLA's view on issues related to the utilization and reimbursement of clinical laboratory services. ACLA is an association representing the leading independent providers of clinical laboratory services, including national, regional and local facilities. All ACLA members will be significantly affected by any action that Congress takes on Medicare reimbursement for laboratories.

As a practicing physician myself for more than 13 years, I know how important clinical laboratory testing is to the delivery of quality health care services. By providing critical information to physicians about a patient's health status, clinical testing is an essential tool in the prevention, diagnosis and treatment of disease; the maintenance of good health; and the delivery and monitoring of effective patient care. ACLA believes it is vital to safeguard patients' access to quality laboratory testing.

Like all health care providers, clinical laboratories have undergone significant reductions in reimbursement in recent years. However, unlike other providers, which have seen reductions in their future rates of increase, laboratories have suffered real cuts in their reimbursement levels. The national limitation amounts, which put a ceiling on the level of clinical laboratory reimbursement, have been consistently reduced over the past eight years. In fact, laboratories are currently in the middle of a three-year reduction in these limitation amounts, which was mandated by OBRA'93. Under those provisions, the national limitation amounts were reduced from 88% of the fee schedule medians in 1993 to 76% of the medians in 1996. In addition, OBRA'93 eliminated the CPI update for laboratory services for 1994 and 1995. These cuts amount to a reduction of over $3.3 billion in laboratory payments over five years.

ACLA recognizes, however, the importance of ensuring that clinical laboratory services are used appropriately, in the most cost-effective manner possible. This morning, I will review several of the actions that ACLA has taken to promote the appropriate utilization and payment of laboratory services and discuss other legislative proposals that will, we believe, further promote these goals. We will also address several other legislative proposals that have been made, which, ACLA believes, would adversely affect the ability of clinical laboratories to provide the highest quality testing services.

In sum, ACLA believes that by clarifying and simplifying the rules applicable to clinical laboratory testing, Medicare will be better able to ensure the appropriate utilization of clinical laboratory services. Further, we believe that enactment of a national direct billing law will reduce utilization for the entire health care system, including Medicare. Finally, ACLA must strongly oppose the reinstatement of coinsurance for laboratories because it will be a burden to beneficiaries, an additional cut for laboratories, and will fail to affect the utilization of testing services.

A. Clarification and Simplification of Clinical Laboratory Ordering and Billing.

ACLA believes that clarification and simplification of the rules applicable to clinical laboratory testing will have a beneficial impact on the utilization of testing. Such actions will ensure that physicians fully understand the impact of their test-ordering decisions; that Medicare pays only for appropriate testing; and that the program can adequately monitor and enforce its laboratory policies. Thus, clarification and simplification should have a beneficial impact on both the utilization and reimbursement of clinical laboratory services.

Because clinical laboratories cannot order tests, it is the physician's responsibility to order the testing that is medically necessary for his or her patients. ACLA believes, however, that laboratories must work with physicians to ensure that they understand the appropriate use of clinical laboratory testing and the impact of their test-ordering decisions on the Medicare program. Thus, ACLA has established guidelines for its members that require them to explain the tests that are included in panels and profiles which are offered, and to provide physicians with information about how Medicare pays for the tests ordered. By working with physicians in this way, laboratories can help ensure that physicians understand the tests they are ordering and the financial impact of their decisions on the Medicare program. In the long run, ACLA believes such increased communication between laboratories and physicians should result in more appropriate utilization of services.

Second, ACLA has worked with HCFA and a variety of medical specialty groups to clarify the rules applicable to "automated multichannel chemistry" testing. In the past, HCFA has expressed concern about the manner in which such testing was ordered, coded and billed. ACLA is working with these groups and HCFA to standardize the rules applicable to such testing. Again, clarifying the rules applicable to this testing will help promote the appropriate use of testing services.

Automated multichannel chemistries are a battery of tests, which are usually performed on automated instruments capable of performing a number of different assays simultaneously on a single specimen. Such tests are billed under a single code number, depending on the number of individual tests included in the panel. The Manual of Physicians' Current Procedural Terminology states that up to 19 specific tests, which it lists, may be included under the codes applicable to automated, multichannel chemistries. However, recently several Medicare carriers have unilaterally included additional tests in the list of testing covered by these codes without also increasing reimbursement. In several instances, carriers have proposed including tests that cannot be performed simultaneously with other multichannel chemistries.

This action has caused great confusion and concern in the industry. Each carrier now has its own list of the tests that it includes under these codes. While some carriers permit certain tests to be billed separately, and reimbursed separately, other carriers pay for them as part of the automated, multichannel chemistry panel. As a result, laboratories with multiple locations must be aware of the different carrier policies for each area where they perform testing.

There is little policy justification today for these vast differences on such a basic issue of laboratory reimbursement. As a result, ACLA has been working closely with other medical specialty groups and HCFA to resolve these issues. As part of this process, in April 1994, ACLA cosponsored, with the American Medical Association and HCFA, the first Consensus Conference on laboratory issues, which was held in Chicago, and attended by representatives of 29 different medical groups. Attendees at the Conference frequently commented that greater uniformity among carriers was needed concerning the rules applicable to clinical laboratory testing.

HCFA has recently issued a new proposal on the billing and payment of these automated multichannel chemistries. ACLA and other groups have submitted comments to HCFA on its proposal, and ACLA will continue to work with the agency and other groups on this policy. If the rules applicable to this testing are clarified, it will help to ensure that physicians understand the impact of their test ordering decisions and that laboratories bill correctly for testing that physicians order.

Third, Medicare's payments for clinical laboratory testing could also be streamlined by eliminating the different rules and policies that apply to clinical laboratories. Today, over 40 different carriers, representing 59 jurisdictions, process Medicare laboratory claims. As noted above, because each carrier often has its own policies covering this testing, the rules applicable to Medicare billing and payment vary, depending on where the test is performed. Thus, a laboratory with facilities in different states must monitor and comply with different payment rules depending on which carrier has jurisdiction. As demonstrated above in the context of automated, multichannel chemistries, such differences on relatively basic issues lead to confusion and wasted effort by all parties, including laboratories, physicians, and the Medicare carriers.

ACLA believes that administrative procedures could be simplified, and costs reduced, if laboratories did not have to deal with numerous, different carriers. It would be far more reasonable if a laboratory with multiple locations could submit all of its claims through a single carrier. In this way, the laboratory would only have to become familiar with a single set of carrier policies and personnel, a change that would greatly simplify the billing process. Although at one time laboratory reimbursement levels varied significantly among carrier jurisdictions--a factor which may have supported the decision to have multiple carriers--those differences are rapidly disappearing. Most testing today is reimbursed at the uniform, national limitation amounts, which cap laboratory payment. Thus, the current system cannot be justified by the existence of significant payment differentials among carriers.

As a result, ACLA urges the Subcommittee to consider recommending a consolidation of the carrier responsibilities for laboratory services, and to encourage the development of uniform policies with respect to coverage and payment issues. We also urge the Subcommittee to consider legislation that would permit laboratories to submit all their claims through a single carrier, regardless of the location of the individual facility performing the testing. We believe that enactment of such policies will help reduce administrative costs for laboratories and the Medicare system.

B. Enactment of Direct Billing Will Promote Appropriate Utilization of Testing.

Appropriate Medicare utilization of laboratory testing would be aided by enactment of a direct billing mandate, i.e., a requirement that the laboratory performing the tests bill the patient or insurer for those services. This provision would simplify the billing structure of the industry and lead to a more rational market for laboratory services. Enactment of such a requirement would promote a more cost-conscious and efficient system for delivery of testing services than currently exists.

Today, laboratories are not required to bill the patient or responsible third-party payor for testing. Billing physicians, rather than patients, promotes the practice of mark-up by the physician, resulting in higher costs to the patient or third-party payor, with no real added value. As reimbursement for the services they provide directly to their patients continues to be reduced, physicians' selection of the laboratory, the number and frequency of tests requested, and the types of tests requested tend to be influenced by the potential for additional income.

In most cases physicians, as wholesale customers, wield sufficient market power to demand and receive significant pricing concessions from laboratories, thus maximizing the potential for mark-ups. The result is that physicians pay lower prices, while other retail payors, including Medicare, pay for laboratory tests at a higher level. Direct billing will eliminate the underlying structural problem that leads to this cost shifting.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). CHPS compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. CHPS found that laboratory prices and utilization were significantly higher in non-direct billing states than in states that require direct billing. CHPS concluded that if a national direct billing law were enacted, annual savings in total health care expenditures of between $2.4 and $3.2 billion could be achieved, as a result of reduced utilization and lower prices. This translates into savings of between $12 and $16 billion over the next five years.

In addition, CHPS also suggested that the enactment of direct billing could help reduce Medicare expenditures for clinical laboratory services. Even though direct billing already exists for Medicare, the CHPS study found that Medicare utilization was lower when the state required direct billing for private payors. CHPS further concluded that this reduction resulted from a spillover effect--that in direct billing states, physicians changed their ordering patterns for both Medicare and non-Medicare patients alike. As a result, utilization of clinical laboratory services reimbursed by Medicare was lower in direct billing states than in non-direct billing states. Therefore, ACLA also urges the Subcommittee to consider the enactment of a national direct billing law.

C. Coinsurance is an Additional Cut for Laboratories .

In the past, some proposals have suggested the reimposition of 20% coinsurance for clinical laboratory services. Coinsurance for clinical laboratory services was eliminated by Congress in 1984, with the approval of the laboratory industry and HCFA, when the current fee schedule methodology was adopted. Under that methodology, coinsurance was eliminated, but the fee schedules were set at 60% of then-prevailing charges. ACLA fully expects the reinstatement of coinsurance to be proposed again in the upcoming debate over Medicare reductions. ACLA opposes this proposal for the reasons discussed below.

First, imposition of coinsurance would constitute an additional cut in laboratory reimbursement because the cost of billing the coinsurance would frequently exceed the amount collected. Although the amount of the coinsurance is often just a few dollars, on average, it would often cost nearly as much just to produce the additional invoice covering the coinsurance. Further, in most instances, laboratories will have to bill several times, thus further increasing the laboratories' costs. Past experience with coinsurance suggests that in many instances, laboratories would have to write off from as much as 50% or more, of the billed amounts due to the uncollectability of these relatively small amounts. Indeed, these problems are the very reason that Congress eliminated the coinsurance requirement in 1984 and mandated the current methodology.

An example will illustrate the actual impact of the reinstatement of coinsurance. The national limitation amount for a Pap Smear, for example, is $7.33. This is the maximum that can be billed for that test, and in many instances, the laboratory is paid even less than this amount. If a 20% coinsurance were applied to this amount, then the laboratory would have to bill the patient for $1.47. If the laboratory has to bill twice to collect that amount, as frequently happens, the laboratory will have to spend 64 cents just in postage. When the additional cost of paper, processing, labor and administrative costs are added in, it becomes clear that the cost of billing will easily exceed the amount the laboratory will collect. Moreover, the fraud and abuse laws would likely be violated if the laboratory just wrote off this amount without trying to collect it.

Reinstatement of coinsurance would also amount to a new burden to beneficiaries. According to some estimates, it would transfer to beneficiaries additional aggregate outlays of approximately $7 billion over five years. Further, because the laboratory usually does not have contact with the patient, the beneficiary often does not know to what laboratory his or her testing is sent. Beneficiaries may, therefore, be confused by receiving a bill for some small amount from an entity, with which they have had no direct contact. This situation only adds to the difficulties of collection.

Furthermore, reimposition of coinsurance amounts to a substantial cut in reimbursement for laboratories, a cut of at least 10%, according to some ACLA members. This reduction, coupled with the cuts imposed by OBRA'93 would amount to a substantial cut in laboratory reimbursement. Such a cut seems especially unfair in view of the fact that laboratories represent only about 5% of Part B expenditures. In addition, such cuts will make it more difficult for laboratories to serve some higher cost areas, including rural areas and nursing homes.

Finally, coinsurance for laboratory services would have no impact on utilization of laboratory services. For ancillary services, such as laboratory testing, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization because patients do not decide when to order testing nor do they select the testing laboratory. Medicare-covered laboratory services can only be ordered by physicians. As the Congressional Budget Office noted in a 1990 Report:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially, ...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.[1]

A recent report by the Office of Technology Assessment came to a similar conclusion.[2]

In sum, ACLA believes that the reinstitution of coinsurance will have a significant, adverse effect on laboratories' ability to provide high quality laboratory services.

D. Competitive Bidding Would Harm Access and Quality.

In addition, last year, the Administration proposed a competitive bidding procedure for the acquisition of laboratory and other services. Although the actual procedures were unclear, the initial proposal appeared to create a "winner take all" approach, which would have given the winning bidder the exclusive right to provide laboratory services within a given geographic area.

ACLA has numerous concerns about such competitive bidding proposals. First, previous federal use of competitive bidding for laboratory services has been unsuccessful and dangerous to patients' health. When the Air Force awarded a contract to a laboratory for screening Pap smears on the basis of competitive bidding, the laboratory, which won the contract because it submitted the lowest bid, performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears that they found contained numerous errors. Other experiments with competitive bidding have encountered similar difficulties.

In many competitive bidding plans, there may be a strong incentive for a bidder to submit a "low ball" bid, in order to obtain the contract, a fact that could have disastrous implications for the quality of the testing. In fact, in 1984, a HCFA report on the laboratory industry expressed great skepticism over competitive bidding. It noted that under a competitive bidding system:

> [l]aboratories might knowingly underprice the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low-bailing," has occurred in even limited competitive contracts for services awarded by the Air Force and by the District of Columbia.[3]

These risks were dramatically illustrated last year by testimony before a House Subcommittee. At a hearing held by a Subcommittee of the House Judiciary Committee in the summer of 1994, a woman testified about her terminal cervical cancer, stemming from a three-year misdiagnosis by her HMO. The HMO had solicited competitive bids for its laboratory services and awarded the contract to a single laboratory that submitted the lowest bid. After three Pap smears and three biopsies, the cancer still went undetected. In short, the use of competitive bidding for laboratory services has consistently resulted in placing quality and patient health at risk. We urge the Subcommittee to reject both the reimposition of coinsurance for laboratories and competitive bidding.

Conclusion

We would like to thank the Subcommittee for this opportunity to submit our views. We look forward to continuing to work with the Subcommittee on these issues. I would be happy to answer any questions you may have.

Doc. #21956

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[1] CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

[2] OTA, "Benefit Design: Patient Cost-Sharing" at 5 (Feb. 1994).

[3] HCFA, *Report of Laboratory Task Force* at 23 (1984).

Chairman THOMAS. Thank you very much for your succinct testimony, covered a lot of ground.

Mr. Willging.

STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, I do represent the American Health Care Association which is the trade association representing by far the vast majority of nursing facilities in this country, including assisted living and subacute facilities.

It is a pleasure to be with you today, Mr. Chairman, although I must admit the pleasure was somewhat less acute when I first read the press release a week or two ago with the focus being the alarming growth of the SNF benefit in Medicare. Perhaps of great concern to me was the following statement: “This may represent significant fraud and abuse.”

I thought at least I would have the opportunity to perhaps put that into a different type context. In doing so, however, I do not for a moment wish to minimize the importance of our efforts, yours, the industry’s, the executive branch’s in ferreting out fraud and abuse in all Medicare programs.

There is no question that how large that is is a factor stimulating the growth of the Medicare SNF benefit. It is in fact something that has got to be dealt with. We have worked and will continue to work with the Congress and the executive branch in making sure that no provider can willfully or intentionally defraud the Federal or State governments and, more importantly, we will work with our own members.

Education is critical. As is going to be suggested in testimony by the American Association of Retired Persons, 75-percent growth in the number of SNFs participating in the Medicare program between the years 1985 and 1993, 6,000 new providers trying to deal with what at best are arcane procedures in terms of billing under part B, and at worse are totally incomprehensible. We have a job, that is, the industry, to make sure that they are educated, even if it is not intentional, even if it is not willful, that we do prevent inappropriate billing.

And finally, oversight. I think we have heard enough today to recognize that the industry I represent cannot assume that this is somebody else’s problem, that this is just incontinent suppliers, shipping off guides to the nursing facility and then billing separately. We, as an industry, each facility is responsible for all services provided in that facility. We have got to be equally responsible for at least providing oversight when it comes to the billing that takes place and we will take that seriously.

We are working with the Health Care Financing Administration to deal with a concept called bundling by some, consolidated billing by others, so that the bills are, in fact, brought together in a place where we can see that they meet the needs of the resident in that facility. That same concept is a part of the proposed prospective reimbursement system that we have been talking to this committee and others about in terms of the Medicare SNF benefit, but as we continue to work toward this legitimate concern of fraud and abuse, let us not confuse that with the underlying factors leading to the growth in the SNF benefit.

As chart 1 will suggest, on the left, the growth between 1993 and 1994 in the SNF benefit was by far largely accounted for by simply population. Of the increase of $1.3 billion in additional growth in the SNF benefit, $800 million, 60-some percent, was population increases, $0.3 billion was price, $0.2 billion was utilization. Even price can contain within it intensity factors so that it is not simply a higher price for the same unit. The unit itself may have changed. For example, as we go from LPNs to RNs delivering an hour of nursing care. So our growth has been, to a considerable extent, more beneficiaries. More utilization, that is, longer lengths of stay in a facility, higher levels of intensity as we move into high acuity patients, and the reasons for those three areas of growth, I think, are clear to all of us.

Certainly it begins way back, 12 or so years ago when the DRG program did what it was supposed to do with respect to hospitals, move patients out of hospitals quicker and sicker. The coverage guideline changes in 1988 for the first time gave Medicare beneficiaries rights to a service that they felt had been denied and that the courts eventually agreed with them had been denied.

The famous catastrophic, or infamous catastrophic legislation back in 1988 developed a new infrastructure in the SNF arena which did not disappear even when catastrophic legislation disappeared 1 year later. And the Nursing Home Reform Act of 1987 where it, one, eliminated the distension between SNFs and ISNFs so everyone essentially became an SNF, also raised the infrastructure level, and two, and perhaps more importantly, put a concept in the law that said, our responsibility as nursing facilities was to bring patients up to the highest practicable level of mental, physical, and psychosocial well-being. Well, if that isn't going to have an impact on the use of therapists in nursing facilities, I don't know what would.

So I think there is no question that the understanding of growth becomes clear when one looks at the factors that make it up. But I think equally important, and at the risk of being considered somewhat too glib, I think there may be areas of growth in the SNF benefit that are extremely beneficial, that we would want to in fact stimulate and foster.

Indeed in the private sector, I know you and your colleagues today, Mr. Chairman, have been looking for what happens in the private sector to control growth in the Medicare program. There are managed care entities. This one, the second chart, happens to be PacifiCare out of California, that are not only not alarmed about growth in the SNF benefit, are stimulating growth in the SNF benefit. That is the lower line; for what effect to see the drop in the upper line. It is called use of subacute care. It is in fact what managed care does so well. And indeed, some of the State programs, not yet Medicare, but at least some of the State programs are recognizing the role of subacute care.

In the last budget presented by Governor Pete Wilson to the legislature in California they are looking for a movement out of the hospital sector into the SNF sector so as to save money, utilizing subacute care within nursing facilities at one-half the cost of a comparable day of care within the hospital.

We have estimated in a study done by Abt Associates that there is a potential of $9 billion per year at the outside admittedly by utilizing subacute facilities in lieu of hospitals.

So in conclusion, yes, let's worry about fraud and abuse. Let's do what we can to ferret it out, to eliminate it to every extent possible, but let's not always assume that growth is bad. I would contend that a dollar of growth in the SNF benefit, which will lead to two dollars of reduction in the hospital benefit, is good growth.

And then the final statement, remember what Dr. Altman told us, let's not forget the synergism among the various component parts of this program. You want to make sure you understand how they interact and not look at each one independently.

I thank you very much for your attention and I would be happy to respond to questions later.

[The prepared statement and attachments follow:]

TESTIMONY OF PAUL WILLGING, PH.D.
AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, another explanation for SNF spending growth is the higher acuity of SNF subcacute patients. As our patient population ages and becomes sicker, and we move more patients into residential care and assisted living facilities, SNF spending will continue to grow. This also corresponds to reduced length of stays in acute care settings which is a desired result from the implementation of the Medicare hospital Prospective Payment System (PPS). This, however, means that patients are discharged sicker and quicker. One important factor here is our movement into quality and cost-effective subacute care.

Skilled nursing facilities offer subacute health care services at an average cost of 47% less than hospital-based SNFs. A report by Abt Associates, Inc. issued last June, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.535 and $8.906 billion depending upon accounting for empty hospital beds and partial waiver of the 3-day stay rule. I recommend that the Subcommittee examine the Abt report in detail to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients.

While it is very difficult to prove that subacute SNF days are replacing acute hospital days, perhaps there is a tell-tale sign in preliminary baseline budget figures released by CBO this month. CBO shows the hospital growth rate increasing at substantially less than previously predicted while the SNF growth rate is increasing, almost correspondingly, faster. Since SNF spending is a small fraction of hospital spending, it makes sense that a small decrease in the anticipated growth in the hospital baseline would show a larger increase in SNF baseline spending if SNFs were competing for, and being utilized more, for subacute patients.

Probably the most important item to look at in terms of the growth in Medicare spending is what are the components of that growth. Our data department ran a comparison of skilled nursing facility expenditures for 1993 and 1994 and found the following:

- Of the factors accounting for the increase from 1993 to 1994 in SNF spending, population accounted for largest amount of the increase compared to utilization and price. Of the $1.3 billion increase, population accounted for $800 million or 62%;

- Of this increase, the costs attributed to price increases showed an increase accounted for only $300 million. This corresponds to an increase in price that is approximately 35% less than the rate of hospital price increases. Clearly our sector specific prices, the only category a provider controls, are going up at a slower rate than hospitals;

- The average length of stay dropped for hospitals and increased for nursing facilities which may correspond to the higher acuity of our patients and entry into subacute care;

- The intensity of services for SNF care increased cost an average of 5 cents more of an increase per patient over hospital patients.

Overall, in examining growth in our costs as an industry, it is not because we are increasing prices and are too profitable, but more clearly because of population demographics and because SNFs are aggressively competing in the health care continuum to treat subacute patients in more cost-efficient settings. Market forces are utilizing SNFs to substitute for more expensive acute care settings. And now, let me outline some of our proposals addressing cost containment.

AHCA COST CONTAINMENT PROPOSALS

I have previously mentioned the Abt study that found a potential of up to $8.9 billion per year in subacute care savings to Medicare. AHCA proposes that hospital subacute DRGs be examined and rebased according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy, and achieve an estimated $500 million per year in savings in just a few years. The SNF stay would be allowed only as a substitution to a hospital stay as certified by the admitting physician.

It is very important that CBO give this proposal a detailed analysis and not shrug off mention of the 3-day stay rule because of prior concerns when the Medicare Catastrophic Act was enacted and soon after repealed. We are talking about direct substitution for acute hospital stays and not new patients coming out of the so-called "woodwork."

Our second proposal involves redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS). I want to express our appreciation, Mr. Chairman, that you and Mr. Stark have supported this concept in the past and helped us move it toward fruition. Indeed, Congress has twice before requested in OBRA'90 and again in OBRA'93 that we move to a PPS by October of this year. HCFA promised this Committee in testimony during late 1993 to have an interim system to you by last June. We are pleased to continue to work with them on a cost-containing prospective payment system, and we have proposed such a system as introduced by Senators Orrin Hatch and David Pryor in the Senate last year.

AHCA is very serious about curtailing administrative costs and building in incentives to save Medicare dollars. We support a case-mix, facility specific PPS that addresses costs in five costs centers: nursing services, administrative costs, fair rental value for property, ancillary services, and therapy services. In regard to current billing practices for medical equipment, we desire strongly to work with HCFA and the Congress to eliminate any fraudulent billing for such items. In addition, we have been meeting and working with HCFA on salary equivalency issues and wish to address any problems with therapies or billing practices that are identified. Our PPS is designed to be revenue neutral, with incentives built in to control future costs, and we believe that it could be designed to curtail unnecessary billings for equipment or special services.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and achieve cost containment. In the past, Congress has requested a PPS for SNFs, and HCFA has promised to develop one. We would request that HCFA honor its word with a balanced and constructive interim PPS proposal that can be put in place this October. We ask Congress to provide a statutory requirement to do so.

One therapy service that is being provided in SNFs but is not reimbursed by Medicare directly is respiratory therapy. AHCA estimates that the cost savings of utilizing SNFs rather than acute care settings in one DRG alone, #483 tracheostomy, the most costly DRG, would save up to $990 million over five years. A 1993 CBO preliminary cost estimate predicted a $100 million revenue loss over five years due to a 10% increase in SNF service utilization. However, the estimate acknowledged that offsetting savings may be realized -- "*if ventilator patients were moved from hospitals to SNFs, then fewer resources might be used in the treatment of these patients.*" We strongly concur.

AHCA requests that your subcommittee reexamine this issue in view of recent data and increased utilization of SNFs for such care despite the lack of direct reimbursement. Hospitals providing ventilator care charge upward of $1,000 per day for such care compared to approximately $350 per day charged by subacute SNFs. Costs billed by hospitals for such care are also driven higher when provided in SNFs under contractual arrangement. Administrative add-ons are also billed, when if the services were provided directly by SNF employees, these costs would not be incurred.

Finally, as I stated earlier, your hearing on managed care could be a more appropriate place for this testimony. You see, managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In recent testimony before the Prospective Payment Commission, Dr. Roger Taylor, Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution. In fact, I have a chart with me demonstrating that PacifiCare has achieved a large part of their savings by reducing hospital stays from 1089 days per thousand members in 1990 to 964 in 1993 and correspondingly increase their SNF days per thousand from 497 to 676.

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, the Medicare Select Demonstration Project should be extended to every state for an extended period of time. In addition, discussions by the House Speaker on reexamining the entire Medicare program and its relationship to private sector efforts in managed care are welcome and should be fruitful. In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs - such as the 3-day stay rule - are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

Let me conclude my remarks on cost containment by endorsing and supporting efforts by the Congress to improve long term care insurance by clarifying income tax rules and providing basic policy standards. Probably the best long-term way to reduce government costs is to build on the private side of the existing public/private partnership for long term care by encouraging more senior citizens to purchase long term care insurance policies early on. A 1994 study by Cohen, Kumar and Wallack found that each long term care policy kept in effect can save Medicaid as much as $15,000 per policyholder.

RELATED ISSUES

Before closing, let me touch briefly on a few final issues. The first concerns proposed regulations by HCFA to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this subcommittee.

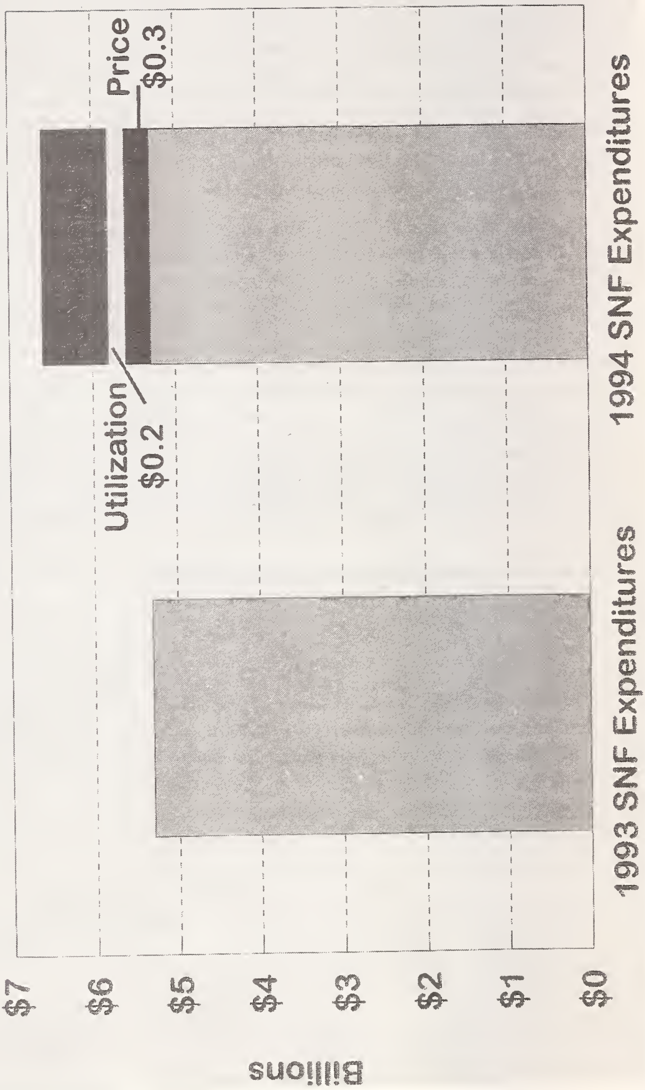
In terms of regulations, you may recall that I have testified before the full committee before that we are one of the most highly regulated industries in America. This is not surprising due to the concern all Americans have over their family members who are away from home and in institutions. However, we recommend an in-depth review of these regulations to determine, which are truly necessary in terms of protecting and improving patient care. Our nurses, our owners, and administrators seem to think that the myriad of regulations imposed on us by literally dozens of governmental entities waste valuable nursing oversight and training and cost patients, the government, and society as a whole billions of dollars. A promising direction is to adopt the outcome measures of managed care in lieu of regulations that specify procedures and inputs.

Finally, in regard to home health care, we applaud efforts to move patients into the least restrictive and most cost-effective setting, but due to the different acuity of nursing facility residents and patients that can be treated at home, we do not see home care as a competing with nursing facilities, only as an essential part of the health care continuum. For instance, average activities of daily living (ADLs) measurements for home health patients are 2.5 of 5 vs. 3.9 of 5 for SNF patients. We would support, however, that copayments be applied equally. SNFs residents are currently burdened with a copayment after 20 days of 1/8th of the annual hospital deductible amount. This is a steep $89.50 per day copayment that almost eliminates any benefit after the 20th day of a SNF stay. We would encourage your subcommittee to impose equal copayments for home care and SNF services outlined by the Congressional Budget Office and eliminate the unworkable current SNF copayment.

Mr. Chairman, let me leave this Subcommittee with a final thought. I have come today to testify and offer you specific proposals to save billions of dollars from the Medicare program. Our nursing facility providers are already operating as probably the most efficient providers in the health care continuum. They have not had a Medicare update since 1990, while according to ProPAC, last year "the overall profit margin for the nation's hospitals reached its highest point since the advent of Medicare's prospective payment system." For instance, our average profit margin in 1991 was only 3.2% compared to average hospital margins of 4.6%. Your examination of nursing facility spending growth under Medicare is warranted and we applaud your efforts. We are, however, more a part of the solution, and not a part of the problem. We encourage you to review our cost containment proposals in time for budget reconciliation later this year, and to review SNF costs centers before determining any potential action. Most of all, we ask you to ensure that a prospective payment system for SNFs be required in statute in time for fiscal year 1996.

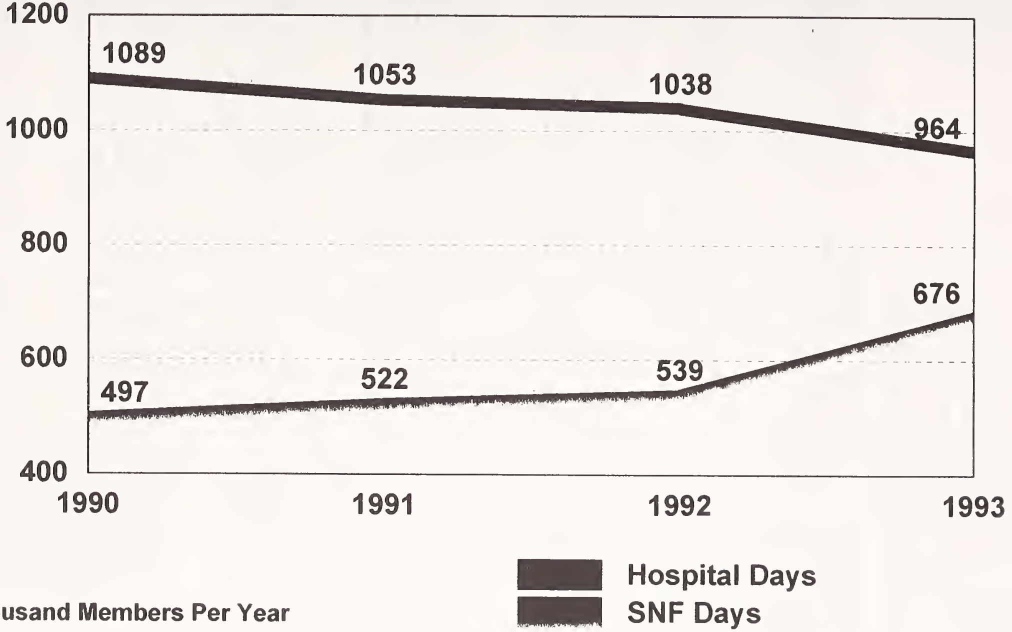
Thank you Mr. Chairman. I'll be glad to answer any questions.

Population Pushes Up Costs



Quicker and Sicker

Utilization Trends 1990 - 1993 *



* Per Thousand Members Per Year
Data from PacifiCare of California

Chairman THOMAS. Thank you Mr. Willging, in your observation about packaging of these hearings, when we put twofers together, it tends toward the blind date syndrome. You don't know what the outcome is going to be. We are trying to whet the appetite of the minority to attend these hearings. Apparently this one didn't work as well as we had hoped.

Mr. WILLGING. Certainly helped my appetite, Mr. Chairman.

Chairman THOMAS. Ms. Suther.

STATEMENT OF MARY SUTHER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION OF TEXAS; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. SUTHER. My name is Mary Suther, and I am president and chief executive officer of the Visiting Nurse Association of Texas. On a daily basis we see over 8,000 patients in both urban and rural areas.

I am representing NAHC, the National Association for Home Care, today. They represent over 6,000 Medicare certified home care service providers. Until this month, I chaired the NAHC government affairs committee for the last 4 years, and I continue to serve on the Fraud and Abuse Task Force.

I would like to commend you, Mr. Chairman, for holding the hearing on issues related to controlling growth in Medicare costs and improving care. NAHC is committed to both these goals. Home health represents a small but growing part of the Medicare program. There are many contributing factors to this growth. But the second part of my testimony will speak to the issues of fraud and abuse in home care.

NAHC has a long history of aggressive action to assure against fraud and abuse and Medicare home health benefit. My testimony will detail NAHC's activities to curb fraud and abuse and provide recommendations to help eradicate these illegal and unethical activities.

Finally, I would like to make some comments about prospective pay for home care. The home care benefit has been maturing for most of its existence in the Medicare program. I have been on this almost 30 years, and I would like to say it is the greatest story never told, but I have heard it told in a way today that I don't want to hear it told again.

The home care benefit became especially useful in the need of meeting patients discharged from the hospital quicker and sicker thus saving Medicare days in those hospitals. Current trends indicate, however, that the home care benefit has peaked and that the Medicare home health expenditure increases will fall to 7.8 percent by 1997.

Both HCFA and NAHC believe that the 1989 to 1992 period of growth was unusual and resulted from several events, including policy and coverage clarifications that resulted in a class action lawsuit, the lessening of personnel shortage which allowed free increase in home health agencies, especially in the rural areas, new requirements, such as home health paid training and competency training, and CLIA was mentioned before, and OSHA, and paperwork, unnecessary paperwork.

The growth of the Medicare home care program is being allocated and can be expected to fall to a modest level within the next 2 years. Sustaining the lower growth rate are a number of underlying factors. Home health has moved well beyond its traditional boundaries making it possible for millions of patients to prevent, reduce, or eliminate the need for more costly inpatient care. The U.S. population is growing older—the significant trend that has and will continue to influence future need for home health services.

Access to in-home services has also improved over the years as much more home health is available for people to choose from. The past decade has seen a dramatic increase in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery of health care services.

Finally, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals. The maturation and simplification of technology has allowed this. As in any area, growth brings with it the potential for illegal behavior. NAHC strongly believes it is the responsibility of all parties involved, patients, payers, and providers, to act aggressively to uncover, report, and act against fraudulent and abusive home care providers.

NAHC has taken a leadership role in combating fraud and abuse. It has engaged in a longstanding effort to maintain the highest degree of ethics. Specifically with regard to the Florida case that the IG mentioned this morning, in April 1994, NAHC met with Inspector General June Gibbs Brown to bring to our attention several areas of fraudulent activity that NAHC had found in that agency.

We suggested a sweeping and aggressive action to eliminate these abuses and take action against this bad apple. In January 1994, NAHC implemented a broad view board policy governing member conduct. The incidence of established fraud and abuse in home care is low, however, even a single occurrence of fraud and abuse is not acceptable and it must be eliminated.

In my written testimony, I have detailed other testimony on fraud and abuse. Let me skip over to prospective pay. NAHC is very interested in prospective pay. We have advocated for a long time that prospective pay provided that it meets the criteria that is necessary to determine what makes a difference in cost and what doesn't. In a per episode reimbursement methodology, the cost would be paid to the provider up front. The provider would be paid one amount for the care of that patient and this would discourage overutilization, it would incentivize the provider.

There is a study that is being conducted by Abt now on that and HCFA has had a lot of input from us on the methodology. Our letter to HCFA is in the testimony. We are very concerned about that study, even though we certainly approve of it. It may not indeed identify the case mix problem that we have identified.

Thank you very much for allowing me to testify today and I will be happy to answer any questions that you have.

[The prepared statement and attachments follow:]

STATEMENT OF MARY SUTHER
VISITING NURSE ASSOCIATION OF TEXAS
ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

My name is Mary Suther. I am president and chief executive officer of the Visiting Nurse Association of Texas, a non-profit home care agency in Dallas. I am pleased to represent the National Association for Home Care at this hearing. NAHC represents nearly 6,000 Medicare-certified home health agencies and hospices, and the individuals they serve. Until this month, I chaired the NAHC Government Affairs Committee for 4 years and continue to serve on its Fraud and Abuse Task Force.

I want to commend you, Mr. Chairman, for calling this important hearing today on issues related to controlling growth in Medicare costs and improving care. As you know, home health represents a small, but growing part of the Medicare program. More enrollees than at any previous time are accessing in-home health services -- about 9 percent in 1994 compared to 2 percent 20 years ago. There are many contributing factors to this growth, and my testimony will attempt to detail the most significant of these.

At the same time, however, we need to make absolutely sure that this growth is appropriate. NAHC has a long history of aggressive action to ensure against fraud and abuse in the Medicare home health benefit. The second part of my testimony will speak to the issues of fraud and abuse in home care and NAHC's activities and recommendations to help eradicate these illegal and unethical activities. Finally, I also would like to take this opportunity to make a few comments about prospective payment.

FACTORS INFLUENCING RECENT AND HISTORICAL INCREASES IN THE UTILIZATION OF MEDICARE'S HOME HEALTH BENEFIT

The home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1 percent of the total. Therefore, although the benefit has increased at an average rate of 23.5 percent per year, it still represents a relatively small proportion of Medicare spending -- only about 8.7 percent of the total estimated for 1995.

Congress has long considered home health care a cost-effective benefit and has taken steps over the years to encourage its utilization. For example, Congress eliminated the prior hospitalization requirement and the 100 visit limit, the home health deductibles, Part B copays and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18 percent compared to only 9 percent in 1981. Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefit's rapid increases over the past 25 years.

Estimates from the Health Care Financing Administration's (HCFA) Office of the Actuary indicates they believe that the benefit has matured and that expenditure increases will fall to 7.8 percent by 1997 (see attached chart).

FACTORS AFFECTING RECENT GROWTH

The home health benefit increases that have occurred in the 1989-1992 period are almost double the 23.5 percent average experienced over the life of the Medicare program but have already begun falling to lower rates. As indicated above, NAHC believes this peaking is temporary and that it has been influenced by several recent events.

Coverage clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, NAHC believes the policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels.

Personnel shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New legislative requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA-87 home health aide training and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New administrative changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

UNDERLYING FACTORS FUELING MODEST GROWTH

As mentioned above, the growth in the Medicare home health benefit is moderating and can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997). Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. Foremost among these is the pursuit of cost-effective alternatives to institutional care.

Cost-Effectiveness. Home health has moved well beyond its traditional boundaries, making it possible for millions of patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. A number of studies have documented the ability of home care to hold down use of more costly care. For example:

- A home health agency in Michigan has developed an in-home cardiac recovery program that reduces the hospital stay for patients who require coronary artery bypass grafting (CABG) surgery by 50 percent. The typical CABG patient requires six to ten days at a hospital. But with the in-home cardiac recovery program, these patients can be discharged within two days of surgery. With hospital charges averaging $1,756 per day, enormous cost savings can be achieved through a four to six day reduction in hospital care. In addition, the study found that CABG patients using home care experienced superior outcomes than those who received longer hospital stays but no post-surgical home care.

- An in-home crisis intervention program developed for psychiatric patients has been effective in reducing hospital admissions, length of stay and readmissions. A two-year analysis, involving more than 600 patients, revealed the following findings: 80.7 percent of patients referred for hospital care could be treated at home instead; when inpatient admissions were necessary, the average length of stay could be reduced from 11.97 days to 7.48 days by adding elements of the in-home care program; and patients who received home care services were less likely to be readmitted for hospital care (11.8 percent of home care patients were readmitted compared to 45.9 percent of patients who did not receive home care services).

- A study conducted by Lewin/ICF examined differences in the cost and effectiveness of inpatient care plus home care versus a shorter inpatient stay and more home care for patients hospitalized with a hip fracture, chronic obstructive pulmonary disease (COPD), and amyotrophic lateral sclerosis (ALS) with pneumonia. It found that for all three diagnoses, cutting inpatient days and substituting more home care days reduced costs by: $2,300 for hip fracture patients, $520 for COPD patients, and $300 for ALS patients.

- An innovative home care program for patients with chronic obstructive pulmonary disease (COPD) that was developed and tested in Connecticut has produced significant cost savings. The overall goal of the program was to provide more comprehensive home care services to COPD patients who previously required frequent hospitalizations. The results found that the per-month costs for hospitalizations, emergency room visits, and home care fell from $2,836 per patient to $2,508 per patient, a savings of $328 per patient per month.

- The American Diabetes Association has conducted research which shows that the total economic cost of diabetes is over $91 billion a year in the U.S. The home care component of these costs is only $37 million or just .04% of the total costs. Yet, studies have proven that aggressive long-term treatment of diabetes conducted in the home significantly reduces the risk of diabetic complications including blindness and kidney failure.

These studies highlight one of the primary reasons that home care will continue to be utilized in the future -- it is a cost-effective benefit that works for millions of Americans.

An Aging Population. The fact that the U.S. population is growing older is a significant trend that has and will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger individuals. For example, the National Medical Expenditures Survey found that individuals over age 85 were three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 63 visits whereas individuals over age 85 used an average of 71 visits.

Improved Access. Access to in-home services has also improved over the years, as more home health agencies choose to participate in the Medicare program. In 1967, there were 1,753 agencies certified for Medicare purposes. By 1980, that number had nearly doubled to 2,924. As of January 1995, a total of 8,100 agencies were providing services under the program. This represents a marked improvement for enrollees' access to home-based services. Currently, there is one agency for every 4,893 Medicare enrollees, compared to one for every 11,136 enrollees in 1967. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38 percent of Americans knew about home care; by 1988, over 90 percent of the public not only understood home care to be an appropriate method of delivering health care, but also supported its expansion to cover long-term care services as well. A new poll conducted in 1992 by Lou Harris and Associates, found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 82 percent of all accredited medical schools now offer home health care in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances have been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Additional Factors. Litigation and workers' compensation claims are two additional factors that affect the cost of delivering home health services.

The Medicare home health program will serve an estimated 3.6 million beneficiaries this year, and expenditures are expected to reach $16 billion. That represents an average increase of nearly 23.5 percent a year in the past 28 years. Much of the increase can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services. Home health growth is beginning to moderate, and it can be expected to fall to more modest levels in the next two years (i.e., to 7.8 percent by 1997).

Sustaining this lowered growth rate are a number of underlying factors that have always influenced growth in home health utilization. These include increased pressure to find cost-effective alternatives to institutional care, a dramatic shift in the age distribution of the US population, improved access to home-based services, and the transfer of hospital technology to the home. These factors in combination with strong public preference for in-home care indicate a future of additional need for and use of home health care.

FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved -- patients, payors, and providers -- to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

The National Association for Home Care (NAHC) has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and it must be eliminated.

The principles of NAHC's policy are as follows:

I. POLICY ON MEMBER SELF-REGULATION

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

II. POLICY ON PUBLIC RELATIONS

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

III. POLICY ON EDUCATION OF MEMBERS

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

IV. POLICY ON ENFORCEMENT

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of a crime and not reporting it would constitute unethical behavior.

Generally, NAHC will not investigate suspected acts of fraud and abuse. However, when government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may act in civil enforcement action where authorized by a super majority of the Board of Directors.

V. POLICY ON SUPPORTING FRAUD AND ABUSE LEGISLATION

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

VI. POLICY ON REQUEST FOR ASSISTANCE

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available where it is determined that it is in the best interests of the home care and hospice industry at large.

This policy is the embodiment of the efforts of NAHC since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sarah Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

The public must also be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concerns. For example, NAHC played a crucial role in exposing issues of home care fraud to the public in a Business Week article in March 1994. (attached) Currently, NAHC is working with ABC News on a developing segment regarding home infusion therapy. NAHC believes that increased public awareness is a valuable means of oversight.

One of the most important roles that the home care industry plays in this area is actively integrating its knowledge and expertise with the enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels NAHC has connected individuals and providers of services who have evidence of fraudulent conduct with the HHS Office of Inspector General. At more involved levels, NAHC has presented a focus for enforcement authorities on where to commit resources in their home care efforts. For example, NAHC met with Inspector General June Gibbs Brown in April 1994 to outline several areas of concern. Specifically, NAHC suggested a sweeping effort to eliminate the abuses existing in the case of subcontracted care by home health agencies, particularly in South Florida. Growing evidence demonstrated the existence of illegal referral kickbacks between Medicare-certified home health agencies and subcontractors, as well as, inadequate safeguards to ensure that billed care was delivered care. Further, NAHC described arrangements that had developed between hospitals and home health agencies where free discharge planning services were provided to hospitals in exchange for patient referrals. This is only one example of how NAHC has actively worked with enforcement authorities including the OIG, FBI, and the GAO. As a final note, NAHC has authorized staff to engage in self-enforcement activities under the False Claims Act to initiate litigation against health care providers where enforcement authorities have not acted to stop illegal activity.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances: financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

RECOMMENDATIONS TO COMBAT FRAUD AND ABUSE

1. Enact all-payor anti-fraud legislation.
2. Provide a private right of action under anti-kickback provisions.
3. Offer "whistleblower" protection for good faith activities of information.
4. Institute an anti-fraud review system at OIG and DOJ where planned activities can be subject to analysis prior to implementation.
5. Commit adequate resources to develop expertise and strategic plans to combat improper underutilization within managed care.
6. Enact provisions to regulate home infusion therapy services.

PROSPECTIVE PAYMENT

Finally, I would like to make a few comments about a prospective payment system (PPS) for home health care. PPS would be one way to create incentives for cost-effective utilization management. For example, in a per-episode PPS model, providers would receive a single payment when a patient is admitted that would cover the entire episode of care rather than paying for individual visits when they occur. In this system, providers would have an incentive to manage utilization in the most cost-effective manner.

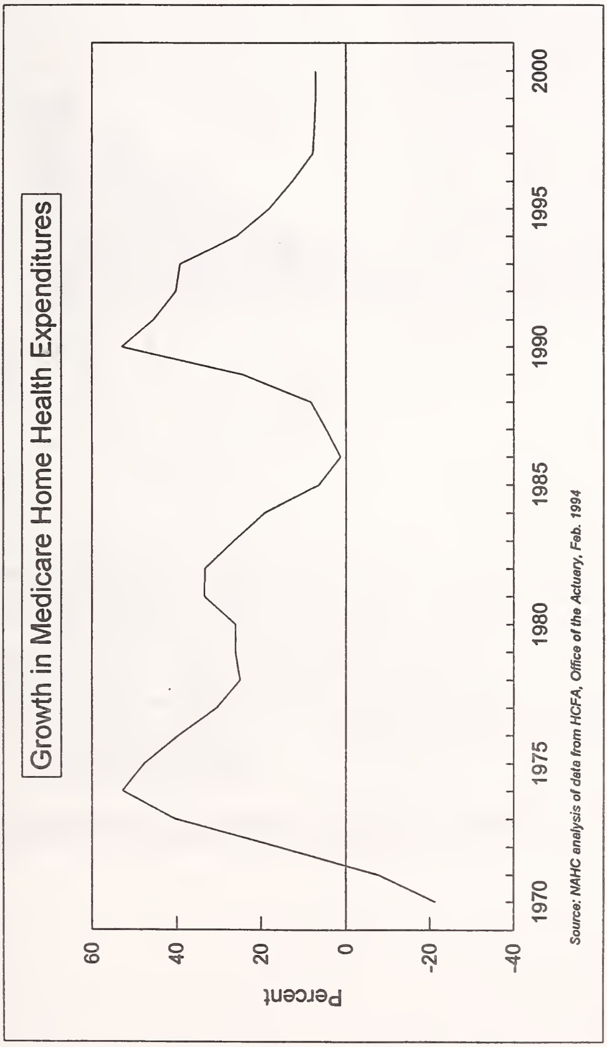
NAHC has long supported a fair and equitable PPS for home health, as long as it has been tested and proven to be an improvement over the current cost-based reimbursement system. To this end, we have been strong supporters of the HCFA demonstrations that would test PPS and the mechanisms within PPS to adjust payments for case-mix variation.

Now, however, we have some concerns about these demonstrations. for one, the demonstration as it is currently constructed, will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. NAHC believes that the demonstration should be reoriented to deal with these case-mix problems now rather than set aside and left for some later time.

NAHC has made a number of recommendations along these lines to HCFA, and we would appreciate any assistance that your committee could provide in urging HCFA to act on these recommendations (see attached letter to HCFA Administrator Bruce Vladeck).

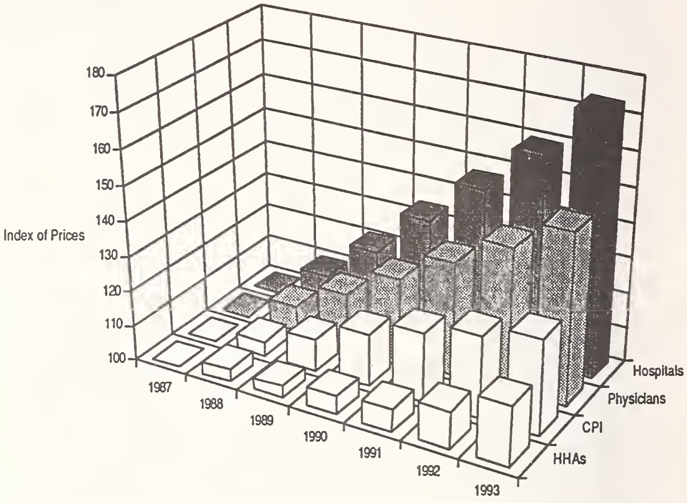
Once again, thank you for the opportunity to testify on these important issues, and I welcome any questions you may have.

HOMECARE



Source: NAHC analysis of data from HCFA, Office of the Actuary, Feb. 1994

NAHC Data Show that Home Care Is Still a Good Buy



Data collected from various sources and analyzed by NAHC show that from 1987 to 1993 the cost of living or consumer price index (CPI) increased by 27.1%, the cost of physician's services increased by 48.5%, and hospital costs soared by 73.4%. By contrast, home care costs increased by only 17% during the same period—about 60% of the increase in the CPI, and far below the rates of increase for other health care providers.

IS FRAUD POISONING HOME HEALTH CARE?

Critics say lax regulations allow overcharging and abuse

Tom Henry had a good thing going. By padding bills for services provided through six home health-care agencies he owned in Lebanon, Tenn., he easily collected more than $4.4 million from Medicare and Medicaid over four years. Henry spent much of the money on a new home, cars, and lavish toys, including furs for his wife, a jaunt with friends to Cancún, and a trip to Hollywood to appear on *Wheel of Fortune* (he lost). Henry was finally caught and convicted of fraud in 1992, after his schemes became too blatant to escape the notice of insurance investigators, who alerted federal authorities.

The case of Tom Henry is only one of countless instances of fraud and abuse plaguing the rapidly expanding $31 billion home health-care industry. Most are purely financial rip-offs, such as one involving a Florida man sent to prison on Feb. 14 for, among other things, billing Medicaid for home care rendered to three people who turned out to be dead. But other crimes involve willful actions of neglect, abuse, and incompetence that jeopardize the lives of the aged and ill people receiving care at home.

Among the myriad scams already uncovered:

- Kelly Kare, a home-care company in New York, sent "untrained, unqualified, and unlicensed workers" to care for sick and elderly patients. Their competence was so lacking that one client, Ronald Callahan, had to have his sister teach his alleged nurse how to catheterize him. By the time Kelly Kare's owner was convicted, she had billed New York Medicaid more than $1.1 million for fraudulent services.
- In Miami, a network of eight companies is charged with offering milk supplements and nutritional therapies free to healthy consumers who didn't need them. The companies then allegedly billed Medicare $14 million, claiming that the products were medically essential. This case, pending in federal court, sparked 14 probes nationwide into similar scams.
- Robert Desrochers, the owner of two home health-care agencies in Alhambra, Calif., paid the salaries of discharge planners at 10 hospitals as part of his service as long as they sent patients to his agencies. He then shifted that cost, among others, to Medicare. He was convicted of fraud last year. Prosecutors say his scheme is not unusual.

Problems in the industry are not limited to newly formed companies or fly-by-night operators. Some of the largest companies in the industry, such as Caremark International Inc. and T2 Medical Inc., are under federal investigation for alleged kickback schemes. Hospital Staffing Services Inc., based in Fort Lauderdale, Fla., is being probed for its Medicare billing practices. All three companies deny wrongdoing.

"NEXT FRONTIER." Predicting how much fraud and abuse costs consumers is tricky. One congressional estimate puts it at 10% of total expenditures, or $3.1 billion. If the current level of malfeasance continues, experts say, it could wipe out some of the anticipated savings from caring for patients outside hospitals. "Home health care is the next major frontier for fraud and abuse," says Edward J. Kuriansky, New York Deputy Attorney General and special prosecutor for Medicaid fraud. "We've just scratched the surface."

Of course, instances of criminal conduct occur in other segments of the health-care industry. But the nature of home care makes it uniquely susceptible. In hospitals, doctors, nurses, and administrators all monitor the quality and cost-effectiveness of care patients receive. But home care is largely unsupervised. With ill-defined or nonexistent pricing guidelines, poorly conceived federal regulations, and a patchwork of uneven state and local laws, the home-care industry is primarily accountable to itself.

Though the industry has tightened its standards, the guidelines have little or no effect on the thousands of home-care companies that don't belong to the trade groups. And federal investigators are far too understaffed to meet the growing caseload. "We've only been dealing with the most blatant cases because of the lack of manpower," says Jeanne K. Damirgian, an assistant U.S. attorney in Miami. "Only now are we moving into more sophisticated schemes."

The fraud epidemic comes at a time when the industry is experiencing exponential growth. More than 7.1 million people are expected to receive some care in their homes in 1994. That's up from 5.9 million in 1987, the industry's trade group says. Home care, which provides the services of nurses and aides, and home infusion therapies, which include delivery of drugs intravenously,

HOME HEALTH-CARE SPENDING IS SOARING...

PHOTO ILLUSTRATION BY MIRIAM FIGMAN [illegible] PHOTOGRAPHS BY [illegible] (PURSE); H. ARMSTRONG ROBERTS (HOUSE); TOM RAYMOND/[illegible] (PATIENT); CHARTS BY JAMIE BEAUCHAMP/BW

are expected to grow 35% in 1994, according to the Commerce Dept.—three times faster than the rest of the health-care industry. The other industry segment, durable medical equipment, such as oxygen tanks and wheelchairs, is also growing fast.

The federal government is picking up a sizable percentage of the tab. Medicare and Medicaid expenditures for home care ballooned to $18 billion last year, from just $8 billion in 1990, according to *Home Health Line*, an industry newsletter. The Health Care Financing Administration, which manages Medicare expenses, predicts a 166% increase in its home-care spending by 1996.

The boom is being fueled largely by the perception that home care is less costly than more traditional venues. A 1991 industry study compared the average cost of treatment in hospitals with treatment in the home for patients with hip fractures, a common ailment treated through home care. It found that by sending patients home six days earlier than normal, $2,300 was saved. That translates into an annual savings of $575 million to Medicare, the study showed.

Such savings, coupled with pressure from insurers to cut costs, is compelling hospitals to release patients sooner. And advances in treatments and technologies have made it possible to provide sophisticated care, such as chemotherapy and respiratory therapy, almost as easily in living rooms as hospitals.

MANY LIMITS. Perhaps nothing has done more for the industry's bullishness of late than the Clinton Administration's plan for health-care reform. Clinton's proposed package specifically calls for universal coverage of short- and long-term home care. Many insurance companies now offer only limited home-care coverage—or none.

Since Clinton's election, Health Force, an owner and franchiser of nursing and home-aide agencies based in Woodbury, N.Y., says that responses to its newspaper ads seeking franchisees have more than doubled to as many as 125 per week. In Louisiana, the number of Medicare-certified home-health agencies jumped from 270 to 442 in 1992. Growth has been so rapid that Louisiana, along with other states, has placed a moratorium on the opening of new agencies.

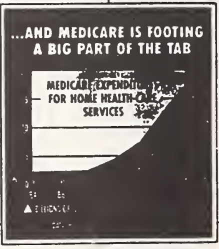
Amid the home-care industry's explosive growth, critics are calling for stepped-up enforcement and better guidelines to regulate providers. Although Congress attempted to make some fixes in 1987 by establishing training standards for home health aides and a national hot line for consumer complaints, abuses have proliferated. "There are so many pieces of home care," says Charles P. Sabatino, assistant director of the American Bar Assn.'s Committee on Legal Problems of the Elderly. "Some are state programs. Some are Medicare. There is licensed, unlicensed, and high-tech home care. And there is no comprehensive approach to accountability."

A look at the regulatory landscape makes that all too clear:

- Only seven states regulate home infusion as a distinct industry, leaving this segment most open to rampant wrongdoing, experts say. "The regulatory environment for these services is a little bit like Dodge City before the marshals showed up," said Representative Ron Wyden (D-Ore.) at a hearing last May.
- Virtually no state or federal licensing requirements exist for the 10,000 companies providing durable medical equipment. Although the industry's trade group, the National Association of Medical Equipment Suppliers, imposes standards on its members, only 20% of the businesses belong to the group.
- For the nursing and home-aide agencies, 10 states and the District of Columbia lack special licensing requirements, though certification through a series of inspections is needed to participate in Medicare and Medicaid. Laws that are in place lack consistency in standards, training, or licensing. Independent providers, which make up $3.5 billion, or 17%, of the home nursing business, operate largely outside any regulatory framework. And no federal law requires these agencies to check whether job applicants have criminal records.

Certainly, the concept of home health care is sound and, when implemented correctly, comparatively economical. And the majority of

...AND MEDICARE IS FOOTING A BIG PART OF THE TAB



PROSECUTOR KURIANSKY: PROBES HAVE "JUST SCRATCHED THE SURFACE"

MOST COMMON FRAUDS IN HOME CARE

PHANTOM SERVICES [illegible]

PADDING BILLS [illegible]

TELEMARKETING DOOR-TO-DOOR SCHEMES [illegible] billing

KICKBACKS Doctors [illegible]

home-care providers do deliver exemplary services. Industry leaders and trade groups have taken it upon themselves to devise rules aimed at ensuring high-quality service. Olsten Corp., based in Westbury, N.Y., the largest provider of nurses and aides for the home, spends close to $2 million annually on compliance programs, which include a criminal background check on job applicants.

But Olsten and some other companies stop short of suggesting that their self-policing mechanisms be applied to the industry at large. Instead, they prefer to rely on a competitive marketplace to wipe out malfeasance.

ETHICS CODE. Trade groups, including the National Association for Home Care, strictly scrutinize their members and have been pushing to expand government oversight. In addition to abiding by Medicare regulations and state laws, members must get the blessing of the Joint Commission on Accreditation of Healthcare Organizations or a similar accrediting body. For accreditation, members must meet stringent standards, including a requirement of 75 hours of training for home-care aides, continuing education for nurses, and agreeing to abide by an ethics code. But these moves only go so far. The standards affect only association members—allowing independent operators to play by their own rules.

So, legislators are readying another try. One bill, scheduled to be introduced in March by Representative Sherrod Brown (D-Ohio) and Senator Howard M. Metzenbaum (D-Ohio), would set limits on prices home infusion firms can charge for their products, establish quality standards for the industry, and require federal licensing. The measure in part responds to protests about extreme disparities in prices for drug therapies offered by home infusion companies (table, page 73). For example, 500 mg of Neupogen, an anti-infection drug, can cost from $266 to $1,128, according to Principal Mutual Life Insurance Co.

C. A. Piccolo, CEO of Caremark, the largest provider of home infusion therapies, concedes that legislation needs to address "escalating costs." But he adds that prices for home-infusion drugs appear high because they reflect numerous overhead costs that must be included in drug charges to get reimbursement from insurance companies. "Insurers won't reimburse us as a line item for services," he says. "They insist that we factor it into the cost of the product."

Another bill, sponsored by Representative Charles E. Schumer (D-N.Y.), would increase funding for health-care fraud investigators as well as provide stiffer penalties for offenders—especially in cases resulting in injury or death to patients. Resources available for uncovering health-care fraud are woefully inadequate. The number of inspectors with

WHO'S BIG IN HOME CARE

1993 TOTAL REVENUES

HOME NURSING AND AIDES $21 BILLION	DURABLE MEDICAL EQUIPMENT $6 BILLION	HOME INFUSION THERAPY $4 BILLION
OLSTEN Westbury, N.Y.	**HOMEDCO GROUP** Fountain Valley, Calif.	**CAREMARK INTERNATIONAL** Northbrook, Ill.
INTERIM HEALTHCARE Fort Lauderdale, Fla.	**ABBEY HEALTHCARE GROUP** Costa Mesa, Calif.	**T2 MEDICAL** Alpharetta, Ga.
VISITING NURSE SERVICES OF NEW YORK New York City	**LINCARE** Clearwater, Fla.	**MEDICAL CARE AMERICA** Dallas

DATA: NATIONAL ASSOCIATION FOR HOME CARE, COMMERCE DEPT., HOME HEALTH LINE

JAMES LUKOSKI/BLACK STAR

the Office of the Inspector General of the Health & Human Services Dept. has been cut to 249 from 298 since 1989, while workloads have multiplied.

On the local level, New York's Erie County set up an employment registry this year to track home-care workers who have criminal records or other troubling pasts. The law was adopted after local police reported a spike in complaints of abuse against senior citizens by home-care workers, including one of an 82 year old blind woman with Alzheimer's disease who was so badly beaten that her ribs were broken. Other patients were persuaded to transfer bank funds to their caretakers or open credit-card accounts for them.

In the private sector, insurance companies have launched their own crackdowns. They more frequently decline to pay bills as submitted, citing unsubstantiated or inflated claims. Principal Mutual is demanding more proof that services billed for were actually delivered and necessary. At Northwestern National Life Insurance Co., a full-time investigator has been assigned solely to reviewing bills submitted for home nursing services.

HUGE BILLS. Perhaps nothing illustrates the potential perils of home care better than the story of Sarah Weber, a little girl in Cleveland Heights, Ohio, who suffered from cerebral palsy. From the age of 5 until her death last July at age 10, Sarah was able to live at home with the help of intravenous drugs and nutritional therapy.

In congressional hearings last May, Sarah's mother, Marie Kostos-Weber, testified that Sarah's bills for her extensive treatments ranged from $95,000 to $120,000 a month—an amount that ate up the family's $1 million private insurance policy limit in less than a year. She stated that after checking with a health-care consultant, she estimated it cost close to $1,000 a day more to treat Sarah at home than in the hospital. When her insurance lapsed, it took a court order to prevent Critical Care America Inc., Sarah's home-infusion provider, based in Westborough, Mass., from cutting off Sarah's supply of medicine, according to congressional records.

But Sarah had other problems. According to a lawsuit Kostos-Weber filed last September against Critical Care, which alleges overcharging and poor quality of care, she contends that the company mistakenly delivered a lethal dose of the wrong drug for Sarah's intravenous therapy. Fortunately, Kostos-Weber caught the mistake, she says. But when she tried to complain to the state health department, she was referred to the Attorney General's office, which in turn referred her to the National Alliance for Infusion Therapy, an industry lobbying group based in Washington. "There was no one to turn to," says Kostos-Weber. "This is a totally unregulated industry. The health department didn't even know what infusion therapy is." Critical Care, which was recently acquired by Caremark for $175 million, declined to comment on the pending litigation except to say that it "will vigorously defend itself."

KOSTOS-WEBER: HER DAUGHTER NEARLY GOT A WRONG DRUG

ROGER MASTROIANNI

THE PRICE ISN'T RIGHT

Range of costs for drugs charged by home-infusion companies*

GANCICLOVIR (400 MILLIGRAMS)	$150 to $800	Used as antiviral treatment for AIDS
NEUPOGEN (300 MILLIGRAMS)	$266 to $1,128	Anti-infection drug
PENTAMIDINE (300 MILLIGRAMS IN SYRINGE)	$180 to $450	Antipneumonia drug
GAMMAGARD (22 GRAMS)	$1,100 to $3,300	AIDS treatment to boost immune system
ROCEPHIN (2 GRAMS)	$147 to $384	Treatment for Lyme disease
ZINACEF (1.5 GRAMS)	$135 to $338	Treatment for various infections

*Charges include certain overhead costs such as delivery and mixing of drug compounds

DATA: PRINCIPAL MUTUAL LIFE INSURANCE CO.

It's clear that as health care moves further into the home, it is bringing a whole new set of problems for providers, insurers, regulators, and consumers. Although greater regulation is essential, lawmakers must be careful not to overregulate. According to a yet-to-be-released study by the George Washington University Health Policy Project, North Carolina, Virginia, and Minnesota have come up with the best regulatory mix. Their laws defining home-health agencies are flexible enough to make most services fall under some regulation. The marketplace, too, will impose more scrutiny and reform, and industry trade groups are trying to improve quality.

CASE MANAGERS. Experts say one of the most effective ways to curtail abuses is to increase the role of doctors. "If there is a power broker in home health-care services, it's the doctor," says William Dombi, director of the Center for Health Care Law in Washington, D.C. The American Medical Assn. has advocated using doctors as case managers for home health-care services. That position is backed by an independent study Aetna Life Insurance Co. concluded in 1993. It found that more physician involvement would curb abusive practices. It noted that in many cases it reviewed, doctors had not even seen the patients for whom they were prescribing treatment.

As the law stands now, doctors have little incentive to take a hands-on approach to home health care. They are not paid by insurers for work relating to home health-care planning.

The eventual shape of health-care reform will likely have the greatest impact on the industry. The Clinton plan does include new criminal penalties for bribes and kickbacks in the home health-care industry as well as tougher civil penalties for falsified billing claims. But these provisions—though they go a long way toward separating the good from the bad players—are only a starting point. The architects of health-care reform must address all the present-day abuses and problems before they inadvertently create a whole host of new ones for the future.

By Linda Himelstein in New York, Gail DeGeorge in Miami, and Eric Schine in Los Angeles, with Ann Therese Palmer and Richard A. Melcher in Chicago

HOMECARE™

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002-5809
(202) 547-7424, FAX (202) 547-3540

KAYE DANIELS
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VAL J. HALAMANDARIS
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HONORABLE FRANK E. MOSS
SENIOR COUNSEL

STANLEY M. BRAND
GENERAL COUNSEL

September 23, 1994

Bruce C. Vladeck, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BDP-779-NC
P.O. Box 7517
Baltimore, MD 21207-0517

Dear Mr. Vladeck:

I am writing to request a meeting with you to discuss plans for phase II of the home health PPS demonstration.

Our concern is that the demonstration will not resolve the case-mix problems that have stymied the development of an acceptable PPS model. Under the demonstration, PPS rates will be based on each agency's own costs during its base year. This is acceptable for a 3-year demonstration but not for an ongoing program. Although a year-end case-mix adjustment will be tested to take account of changes that may have occurred since an agency's base year, that adjustor has practically no predictive value. Its R-squared value is only 9.79 percent. This poor performance could be improved by the inclusion of additional variables. A model consisting of 40 some data elements has been developed that has been given high marks for its predictive power.

Indicative of the weakness of the system is the fact that the demonstration designers have found it necessary to protect participants against 99%, 98% and 97% of any losses in demonstration years one, two and three respectively.

It seems to us that the demonstration neither satisfies the mandate in OBRA-90, which calls for the development of a new payment system, nor the widespread desire to find a cost-effective alternative to cost reimbursement. NAHC believes that the case-mix problems should be dealt with now rather than set aside and left for some later time -- presumably 5 years or so from now when the current study is completed.

While we made our concerns known when we first learned of the design of the demonstration last month at an industry briefing and have subsequently offered to discuss the matter further, we have now reached a point where we are concerned that we may be running out of time. Home health agencies will be recruited to participate in the demonstration in the near future.

If you would like to have any additional information, please call me or Bob Hoyer, our Vice-President for Public Policy and Research.

Sincerely,

Val J. Halamandaris
President

Chairman THOMAS. Thank you very much, Ms. Suther.

Mr. Lehrmann.

STATEMENT OF EUGENE LEHRMANN, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. LEHRMANN. Thank you, Mr. Chairman. I am Gene Lehrmann, president of the AARP. I appreciate the opportunity to appear before the subcommittee today to discuss Medicare spending.

Unrestrained growth of costs systemwide drives Medicare spending. Attempts to restrain Medicare without also controlling costs throughout the health care system will fall short, and most likely will result in greater cost shifting onto beneficiaries and the private sector. Moreover, savings from Medicare should not be used to finance tax provisions.

Contrary to what some have stated, Medicare is one of the most cost-efficient Federal programs. Medicare returns between 96 and 99 cents on the dollar. By contrast, administrative costs of private health insurance range from at least 5 to 40 percent of benefit costs.

Since the early eighties, Medicare spending growth has been cut by over $200 billion and strong cost containment provisions on hospitals and doctors have been implemented. As a result, for much of this period, growth in per capita spending for Medicare has been below per capita growth in the private sector.

The rapid rates of growth in Medicare home health and skilled nursing facilities have raised important questions about the reasons for such growth. Numerous studies are now scrutinizing these benefits to look at fraud and abuse concerns, dramatic State and regional differences in growth rates and payment and administrative reforms.

If there are problems with these benefits, then we must address them, but we should act based on a sound diagnosis rather than only on symptoms. We urge this subcommittee not to simply impose shortsighted budget cuts in these programs as a way of complying with arbitrary targets to pay for tax and benefit reductions.

In our view, an objective reading of the available evidence leads to the conclusion that growth rates are due in a large part to clarifications of coverage rules in these benefits in the late eighties that previously had been ambiguous and overly restrictive.

These court-ordered clarifications address the serious denials of Medicare SNF and home health claims that artificially constrained access to these critical rehabilitative services during the eighties. As a result of the clarifications, provider confidence and participations in these programs grew. Not only was beneficiary access to care improved, new small businesses were created. Competition increased and geographic distribution of services improved.

Another factor in the growth of these benefits was important, new technologies that enabled beneficiaries to leave the hospital earlier and receive care in a less expensive setting.

Since the major causes of growth in these programs can be attributed to improvements in program administration in the late eighties, the rate of growth in these programs are likely to be short lived. Many predict that growth in the home health program, for example, will soon flatten by itself without any legislative or regulatory reforms.

While controlling abuses is absolutely essential, these estimates demonstrate that drastic measures are not needed to slow the future rate of growth in the Medicare home health care program.

We urge the subcommittee to reject the assumption that the growth rates are a result of inappropriate utilization by beneficiaries. There is no clear or convincing evidence to support such an assumption. Moreover, unduly restricting access to home health services through the imposition of an onerous, regressive beneficiary copayment, for example, would seriously harm the most vulnerable oldest Americans, those who can afford least to pay for it.

For the average Medicare home health user, a new 20-percent coinsurance would require them to pay an additional $1,300 out-of-pocket in 2002. The average payment for those who need and use the benefit the most, primarily lower income older women, would be over $4,200 in 2002. The group likely to suffer the most from such a tax is the almost one-quarter of home health users with incomes of between 100 and 150 percent of poverty, too high to qualify for protection under the qualified Medicare beneficiary program and too low to be able to afford a Medigap policy to cover these new costs.

Medicare is a successful and popular program that provides essential services for older and disabled Americans. Administration of the program has been more efficient than many think and costs have been effectively contained, although improvements can be made.

Medicare home health and SNF growth rates raise legitimate questions about the operation and the administration of these important benefits. We would be pleased to work with members of the subcommittee to discuss mechanisms for improving the efficiency and cost-effectiveness of the Medicare program.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF EUGENE LEHRMANN
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee. I am Gene Lehrmann from Madison, Wisconsin. I am President of the American Association of Retired Persons (AARP). I appreciate the opportunity to appear before the Subcommittee today to discuss Medicare spending.

AARP believes that measures to control spending in the Medicare program will fall far short of their goal unless action is taken to control costs throughout the health care system. The unrestrained growth of costs systemwide drives Medicare spending. Attempts to restrain Medicare without also controlling costs throughout the health care system will fall short, and most likely will result in greater cost-shifting onto beneficiaries and the private sector.

AARP believes that, while some refinements are inevitable and necessary as our nation's health care system changes, Medicare must remain a viable health insurance program that provides affordable coverage to older and disabled Americans. To this end, Congress must carefully consider the impact of proposals to restrain program spending -- on the program and on beneficiaries and providers. Moreover, savings from Medicare should not be used to finance tax provisions such as those in the Contract with America.

MEDICARE IS ESSENTIAL

Medicare is the federal health insurance program for the aged and disabled. Created by Congress in 1965, it now provides medical care coverage for roughly 37 million older and disabled people. Medicare is a social insurance program. Individuals pay into the Medicare Hospital Insurance (HI) Trust Fund during their working years through a payroll tax and when they retire they are eligible for the health insurance benefits they have earned. They pay a premium roughly equivalent to 25% of Medicare Part B costs as beneficiaries.

Medicare pays for a wide range of health services. Medicare Part A helps to cover the costs of hospital coverage, skilled nursing facility care, home health care and hospice for the terminally ill. Part B covers physician services, outpatient care, diagnostic tests and durable medical equipment. Medicare does not discriminate -- no beneficiary is excluded from coverage because he or she has a pre-existing condition.

One of the most important elements of Medicare is the protection of beneficiary choice -- beneficiaries can choose where and from whom to receive care -- from physicians or certain non-physician practitioners, through a standard fee-for-service plan or a managed care setting.

Contrary to what some have stated, Medicare is one of the most cost efficient federal programs. Of the roughly $94 billion spent on Medicare Part A hospital benefits in 1993, only 1 percent was spent on administrative expenses. Of the roughly $42 billion spent on Medicare Part B physician benefits in 1993, only 3.6 percent was spent on administrative expenses. This means that Medicare returns between 96 and 99 cents on the dollar. By contrast, administrative costs of private health insurance range from at least 5 percent to 40 percent of benefit costs.

Poll after poll indicates strong support for Medicare across all age groups. While they may be many years away from eligibility, there is recognition among those under the age of 65 that Medicare lessens the burden on families who would otherwise end up paying the medical bills -- often enormous -- of parents and grandparents.

MEDICARE SPENDING HAS BEEN SLOWED

Those who try to blame Medicare for unsustainable spending are ignoring a critical fact: in order to impose real cost constraints on Medicare, private sector health spending must be constrained as well. Since the early 1980s Medicare spending growth has been cut by over $200 billion and strong cost containment provisions on hospitals and doctor payments have been implemented. As a result, for much of this period growth in per capita spending for Medicare has been below per capita growth in the private sector. While this trend was reversed for a two year period between 1992-93, HCFA indicates that a slower per capita growth in Medicare is likely to continue. This experience amply demonstrates the need for system-wide cost containment.

Spending in Medicare is affected, to a large degree, by the same factors that cause unsustained spending growth in the private sector: intensity of services, the use of new technologies that allow the treatment of more complex and costlier cases, fraud and abuse, and changes in the population.

The slowing in Medicare's growth may be attributed, in part, to reimbursement and cost containment mechanisms that have been implemented over the past several years. The implementation of physician payment reform has had an impact on slowing the growth of physician expenditures in Medicare. According to the Physician Payment Review Commission (PPRC), expenditures for physician services slowed to an average rate of 3.8 percent from 1991-93 compared to 10.5 during the preceding five years. In this same period volume growth also slowed.

The Prospective Payment Assessment Commission (ProPAC), has found that hospital growth has varied over the last several years but cost growth appears to have slowed again in 1993. Some of the decreases are due to an increase in the use of hospital outpatient services that constitute a growing share of the revenues hospitals receive from Medicare. This growth in hospital outpatient usage is proving problematic for beneficiaries because of a serious problem with the coinsurance calculation.

Because beneficiary coinsurance for most hospital outpatient services is based on what the hospital charges, rather than on what Medicare reimburses, beneficiaries may wind up paying upwards of 50 percent in coinsurance for outpatient services. This has created an incentive for hospitals to direct more patients into an outpatient setting and shift more costs onto beneficiaries. **As this Committee examines those aspects of the Medicare program that have been growing quickly, we urge you not to overlook this serious circumstance in outpatient services where extraordinary and unmanageable costs are being shifted onto beneficiaries.**

MEDICARE CHALLENGE FOR CONTROLLING SPENDING: GROWTH IN THE MEDICARE HOME HEALTH AND SKILLED NURSING FACILITY BENEFITS

Since 1988, the rates of growth in the Medicare home health and skilled nursing facility (SNF) benefits have exceeded those in the rest of the program. This has raised important and legitimate questions about the reasons for this growth and whether they reflect overutilization by beneficiaries. In our view, an objective reading of the available evidence leads to the conclusion that the growth rates are due, in large part, to clarifications of coverage rules in these benefits in the late 1980's that previously had been very ambiguous and overly restrictive. These ambiguities caused artificial, as well as illegal, constraints on the availability of these services for beneficiaries. For home health in particular, growth rates from 1984 to 1988 were flat and, in some years, actually declined. Beginning in 1989, court ordered coverage changes and the issuance of new intermediary coverage rules increased the number of meritorious claims submitted for Medicare coverage. Many similar claims previously had not been submitted by providers because they feared denials and having to absorb the costs themselves.

We urge the subcommittee to reject the assumption that the growth rates are the result of inappropriate utilization by beneficiaries. There is no clear or convincing evidence to support such an assumption. Moreover, unduly restricting access to home health services through the imposition of an onerous, regressive beneficiary copayment, for example, would seriously harm the most vulnerable, oldest Americans -- those who can least afford it.

Additional research is currently underway to investigate possible billing abuses by providers, the alarming variations in utilization patterns across geographic regions, and growth in the demand for so-called "subacute" care. HCFA also has undertaken a comprehensive study of the Medicare home health program, which has and will continue to recommend and implement reforms to improve the program's efficiency. Preliminary evidence from researchers at Duke University supported by HCFA suggests that growth in the use of home health has occurred among patients with very serious health problems and that cost substitutions may be occurring, as well as positive age-adjusted reductions in long term institutional use. These important initiatives are aimed at identifying the real causes of any problems and proposing targeted and appropriate solutions. We urge this committee not to simply impose short-sighted budget cuts in these programs as a way of complying with arbitrary targets to pay for tax and deficit reductions. **If there is abuse of these benefits then we must address it -- but we should act based on a sound diagnosis rather than only symptoms.**

Background -- Medicare Home Health and SNF -- To qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time care skilled care (skilled nursing or therapy). The need for assistance with daily living activities does not trigger coverage. Persons who need daily care for more than a few weeks also are denied coverage.

To qualify for Medicare SNF coverage, a beneficiary must have had a recent prior hospitalization of at least three days. The services needed must be skilled (not custodial) and medically necessary. The most common diagnoses for SNF Medicare patients are strokes and hip fractures. Coverage is limited to 100 days per spell of illness. On average, the length of a covered stay is approximately 30 days. A copayment of $89.50 is imposed for days 21-100. Rather than basing this copayment on the cost of care, it is based on a formula equal to one-eighth of the hospital deductible amount. **In many areas of the country, this coinsurance amount exceeds what most would consider to be a reasonable daily rate relative to actual daily SNF costs. In other words, beneficiaries often are paying -- out-of-pocket -- more for this benefit than it is actually worth.**

The Medicare home health and SNF benefits are designed primarily to provide rehabilitation, typically after a hospitalization. While all SNF stays follow a hospitalization, approximately two-thirds of Medicare home health users begin their episodes of care within 30 days of being discharged from an inpatient stay. According to ProPAC, almost 70 percent of Medicare beneficiaries hospitalized in 1990 with a hip fracture received post-hospital care from a SNF, Home Health Agency (HHA), rehabilitation hospital, or some combination of the three. Access to these services is critical to proper recuperation and the ability to remain in the community. Such access also permits hospitals to discharge patients earlier and in a more unstable condition than in the past, thereby saving money both through hospital length-of-stay and reduced readmissions. Between 1979 and 1991, for example, average length of stay in hospitals for persons over 65 years of age declined from 10.8 days to 8.6 days.

Problems with the Medicare Home Health and SNF Programs in the 1980's -- When the Medicare hospital DRG prospective payment system was enacted in 1983, it was anticipated that use of post-hospital care would increase in order to care for patients who were being discharged from the hospital sooner than in the past, but were still in need of care. Indeed, since 1983, researchers have documented the increasing severity and instability of illness among patients in nursing homes and receiving home health care.

However, instead of the expected increase in SNF and home health utilization after DRGs were implemented, the opposite occurred. The number of SNF days per patient dropped 25% from 1984-1986. An average of one-third of all claims for SNF coverage were being denied. Moreover, the denials were not consistent throughout the country. A claim accepted by an intermediary in one area would be denied by the same intermediary in another. Denial rates ranged from 10% in Denver to over 40% in Boston and 60% in New York. Within the same region, different intermediaries were making different decisions on similar claims.

The experience with Medicare home health utilization was similar. Home health was expected to increase once DRGs were implemented, but it did not. A 1988 CBO analysis reported a $2 billion reduction from projected spending on Medicare home health services between 1984 and 1988. The number of Medicare home health denials of coverage increased from about 186,000 in 1985 to 408,000 in 1987. Since providers generally must absorb the cost of services rendered for submitted claims that are subsequently denied, the impact of provider behavior was substantial. According to one study, "The 1980's witnessed a serious crisis with denial of Medicare claims for home health benefits, threatening access to home health care for aged and disabled Americans."[1] Unexplainable variation in HHA denial rates among regions was also problematic. According to GAO, in the late 1980's "HCFA's quarterly data on denials of home health agency bills show significant variation of denial rates among HCFA regions."[2] As a result, according to a 1989 report to Congress:

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[1] Kinney, Eleanor, et al, "Home Health Agency Response to the Medicare Claim Denial Crisis of the 1980s," Indiana University School of Law, June 1989 (pg. v).

> "beneficiaries and providers were increasingly confused about Medicare coverage criteria; a 'chilling effect' set in, causing HHAs to reduce the number of services provided to a beneficiary in an effort to avoid costly denials; and a lack of trust existed between HCFA, FIs, and the provider community."[3]

In a 1987 GAO report which surveyed 850 hospital discharge planners, 97% reported having problems placing Medicare patients in skilled nursing facilities, and 86% reported problems with home health placements. The discharge planners cited Medicare rules as the most significant barrier to placement of patients in SNF and home health.

Changes to Clarify Medicare Home Health and SNF Coverage Rules -- In 1987, Medicare beneficiaries, with support from providers and AARP, sued the Department of Health and Human Services, claiming that improper administration was resulting in arbitrary denials of home health services to eligible beneficiaries. In August, 1988, the United States District Court for the District of Columbia ruled that thousands of Medicare beneficiaries had been denied Medicare home health coverage illegally as a result of improper administration of the benefit. Duggan v. Bowen, 691 F.Supp. 1487 (D.D.C. 1988). The court invalidated HCFA's policy of restricting all home health coverage to four or fewer days per week. To implement the ruling, HCFA agreed to cover skilled care, therapy, or home health aide services in any combination, up to 28 hours per week, and up to 35 hours upon individual determination by the fiscal intermediary of the reasonableness and necessity for the additional care. HCFA also agreed to rewrite the Medicare Home Health Coverage Manual, consistent with the court's order. Implementation of the court's order has resulted in increased access to home health coverage for Medicare beneficiaries. These, however, are appropriate, needed services, to which beneficiaries are legally entitled.

AARP and others also pressed HCFA for correction of the unacceptable ambiguities and variations in SNF coverage and demonstrated how the guidelines failed to reflect the legal standards under the Medicare law. HCFA published revised guidelines in 1988, which are faithful to the law and regulations and which, for the first time, offered concrete guidance to intermediaries on how to evaluate claims. Those guidelines have resulted in appropriate increased coverage, so that needed and covered services are provided to beneficiaries.

A March, 1994 ProPAC report concluded that the growth in Medicare home health "can be attributed primarily to coverage guideline changes and other administrative factors affecting use."[4] The report goes on to say that the coverage changes "resulted in more people receiving home health services and more services being provided per beneficiary." (See attached Chart 1). The "administrative factors" referred to represented long overdue improvements and clarifications in the benefit; they were implemented in 1987 and included: (1) elimination of an arbitrary rule imposed on fiscal intermediaries(FIs) that had provided strong incentives for them to save five dollars through medical review claims denials for each dollar spent reviewing the claims (so-called 5 to 1 "savings-payback ratios"); (2) providers were given better information about why claims were denied so they could avoid future mistakes; and (3) providers were given the opportunity to supplement claims submissions so that they would no longer be denied merely because necessary information was missing.
In part, recent program growth could be interpreted as "catching up" to where it would have otherwise been but for efforts between 1984 and 1988 to illegally or unfairly limit growth.

Increases in Provider Participation -- Another important factor contributing to program growth that resulted primarily from the home health and SNF policy clarifications was increased provider confidence and participation in these programs. For example, the number of Medicare certified HHAs increased from 5,780 in 1991 to 7,360 in March 1994 -- an increase of over 27% in a relatively short period of time. The number of Medicare certified SNFs increased from 6,451 in 1985 to 11,309 in 1993 -- an increase of 75% in 8 years. Increasing provider participation, in general, is a positive trend. Not only does it afford beneficiaries access to care, but new small businesses and jobs are created, which benefit our economy. Reductions in entry barriers improve the market and should increase competition, leading to better services, lower prices and greater geographic distribution. In the past, for example, residents of some rural areas had a very difficult time finding these services because they simply were not available.

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[2] GAO, Increasing Denials of Home Health Claims During 1986 and 1987, HRD-90-14BR; January 1990 (page 22).

[3] Advisory Committee on Home Health Claims, U.S. DHHS; July 1989 (page 9).

[4] ProPAC, Interim Analysis of Payment Reform for Home Health Services, C-94-02; March 1994 (page 8).

Between 1980 and 1993, hospital-based HHAs (as opposed to free-standing agencies not owned by hospitals) grew from 12.3% to 27% of all HHAs. During that same period, growth of proprietary HHAs was even more dramatic -- from **6.4% to 48%** of all HHAs. Data indicates that proprietary agencies have longer episodes of care and provide substantially more visits per episode than non-profit agencies. In all likelihood, this change in the composition of the provider community also contributed to program growth.

Without question, improvements in the SNF Medicare program also boosted provider confidence and participation. According to a 1992 ProPAC report:

> "The [SNF] Medicare program may also seem relatively unattractive because of the administrative burden associated with it. Under Medicare, coverage determinations are made by the fiscal intermediary after a patient has been admitted. Retroactive denial of Medicare coverage is not uncommon. For this reason, nursing homes may be reluctant to admit Medicare patients in favor of private pay or Medicaid patients. *However, this problem has been rectified somewhat by the 1988 coverage guidelines clarification.*"[5] [emphasis added]

The report also cites the Medicare Catastrophic Coverage Act (MCCA), which eliminated the prior hospitalization requirement in 1988, as a factor contributing to increased provider participation. It found that "Even though MCCA was subsequently repealed, the higher number of Medicare certified beds remained, probably due to the impact of the clarification of coverage guidelines."[6] OBRA '87, which eliminated the distinction between SNFs and ICFs, also contributed to the increase in participation because facilities no longer had to increase staffing or services to become Medicare certified. Currently, nursing facilities' interest in the growing "subacute care" market, which is paid primarily under the SNF Medicare program, continues to contribute to growth in participation.

Advances in Technology in Post-Acute Care -- Several important new technologies have enabled Medicare beneficiaries to leave the hospital earlier and receive appropriate care in a less expensive setting. For example, home infusion therapy became available in the early 1980's and, for the first time, permitted cancer, organ transplant and heart failure patients, as well as those needing intravenous antibiotics, pain medication and parenteral nutrition to receive care at home. In addition, home ventilators are now more compact and convenient, enabling many who had previously been dependent on heavy machinery to stay at home.

Nursing facilities' interest in subacute care has also been driven, in part, by the availability of new technologies. According to a recent HHS report: "Technological advances have made it possible for medically complex and/or technologically advanced services previously provided only in acute care hospitals to be more frequently delivered in non-hospital settings."[7]

Billing Abuses in the Medicare Home Health and SNF Programs -- Fraudulent and abusive billing practices currently cost our nation's health care system over $100 billion a year. Although no part of the health care system seems to be immune, major patterns of abuse have been found to exist in the use of durable medical equipment (DME) during SNF stays, and in the home health care industry.

An October, 1994 report by the HHS Office of the Inspector General found that between 1991 and 1992 over $19 million dollars was incorrectly allowed for durable medical equipment billed to Medicare during stays at skilled nursing facilities. Moreover, the report found that incorrect equipment billings during a skilled stay turned out to be for items prescribed for use before or after the stay had actually occurred. A companion report issued that same month also seriously questioned the appropriateness of shifting millions of dollars each year for SNF services covered under Medicare Part A to Part B, creating additional beneficiary liability.

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[5] ProPAC, Medicare's Skilled Nursing Facility Payment Reform, C-92-01; March 1992 (page 40).

[6] Ibid., page 38.

[7] DHHS Office of the Assistant Secretary for Planning and Evaluation, Subacute Care: Policy Synthesis and Research Agenda, 1994 (page 1).

The GAO has also been working on a report to look at SNF Part B billing practices. Preliminary findings last year indicated serious abuses.

Similar instances of abuse can be found in the home health care industry. Sen. William Cohen (R-ME) issued an investigative report in July, 1994 which found several abusive billing practices, such as billing for services not rendered and kickbacks to referring physicians. In his report Sen. Cohen stated, "Home health care has tremendous potential to decrease costs of both acute and long-term care and to enhance patients' quality of life. It also, however, presents a disproportionate opportunity for abusive practices, hidden from medical professionals and overseers who cannot watch delivery of care at home."
Long-Term Estimates of Medicare Home Health and SNF Growth -- Since the major causes of growth in the Medicare home health and SNF programs can be attributed to improvements in program administration in the late 1980's, the substantial rates of growth in these programs are likely to be short-lived. Many predict that growth in the home health program, for example, will soon flatten by itself, without any legislative or regulatory reforms. **Just last month, HCFA projected that next year, growth rates in Medicare home health benefit payments would decline by almost one-third**, from 18.9% for 1994-1995 to 12.8% for 1995-1996. During this same period, **Medicare SNF growth rates are projected to decline by 36%**, from 26.9% to 17.1%.

In our view, the greater concern lies with controlling the relatively more rapid SNF Medicare growth rates. According to ProPAC: "Between 1995 and 1999, home health expenditure growth is projected to level off at an average annual rate of 9.8% per year."[8] In addition, HCFA's Office of the Actuary has projected that, after 2002, annual growth in Medicare home health expenditures will level off at approximately 6.7% and annual growth in the number of visits received by beneficiaries will level off at approximately 1.5%. (See attached Chart 2) While we acknowledge that projections that far into the future are quite speculative, they do help to show that most experts believe that current growth rates won't be sustained. In our view, these estimates clearly demonstrate that drastic measures are not needed to slow the future rate of growth in the Medicare home health program, but action to root out abuse should be undertaken -- and vigorously.

Need for Additional Analysis on the Causes of Program Growth -- Clearly, the recent rates of growth in the Medicare home health and SNF programs have not gone unnoticed. The programs are being closely scrutinized by the Office of the Inspector General, the General Accounting Office, the Office of the Assistant Secretary for Planning and Evaluation, ProPAC and HCFA. In fact, HCFA recently launched an extensive Medicare home health initiative designed to provide a comprehensive assessment of the program. Among the stated goals of the initiative, in which AARP has been a participant, are enhancing efforts to detect fraud and abuse; improving the efficiency of the program's administration and operations; facilitating appropriate utilization of home health services; and ensuring appropriate payments for the benefit.

There are also some dramatic regional and state variations in the growth and use of the benefits that need further investigation. For example, according to a recent report by Mathematica:

> "Consistent with earlier studies, we found a threefold difference in the (nonregression-adjusted) use of Medicare home health services between the East South Central region of the United States (Alabama, Kentucky, Mississippi, and Tennessee), where episodes included 95 visits and were 180 days long, on average, and the Pacific region (Alaska, California, Hawaii, Oregon and Washington), where episodes included 28 visits and were 60 days long, on average. Home health use was also markedly higher than average in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) and markedly lower in the Middle Atlantic region (New Jersey, New York, and Pennsylvania)."[9]

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[8] Supra, note 4 at 13.

[9] Mathematica Policy Research, Inc., "Patient, Agency, and Area Characteristics Associated with Regional Variations in the Use of Medicare Home Health Services," September 1994 (page xiv).

There are a variety of ways to assure appropriate utilization without harming beneficiaries in need of care. For example, consideration should be given to expanding the role of physicians, who are responsible for certifying that services are medically necessary. This may be particularly timely since, as of January 1, physicians can now bill Medicare for care plan management and oversight for patients receiving home health benefits. The OIG documented a serious absence of physician visits to many SNF residents in 1991-1992.

In addition, Peer Review Organizations (PROs), which have not been empowered to carry out their statutory obligation to review the appropriateness of Medicare post-acute care, could do more in this area.

Payment reform initiatives also have the potential for making programs more efficient. The On Lok and PACE demonstration programs, which are experimenting with capitated payments for these services within an integrated system, should be expanded and thoroughly evaluated. Findings from studies and demonstrations on prospective reimbursement for Medicare home heath and SNF services could also lead to constraints on program costs. Prospective payment for SNFs seems more promising in the short term and we urge that particular attention be paid to Part B payments, which have not been subject to the same cost limits as those in Part A. We also look forward to evaluations resulting from home health demonstrations on per-episode reimbursement. Any new payment systems, however, must include adjustments for case-mix so that there are not disincentives to treating patients with heavy care needs.

Proposals to Impose a New 20% Medicare Home Health Coinsurance -- Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services. Some members of Congress have proposed the imposition of a new 20% coinsurance on users of Medicare home health. In our view, such a regressive proposal would create great hardship among the most vulnerable Medicare beneficiaries -- particularly older, lower income women. The group likely to suffer the most is the approximately 24% of users with incomes between 100% and 150% of poverty -- too high to qualify for protection under the Qualified Medicare Beneficiary (QMB) program, and too low to be able to afford a Medigap policy to cover these new out-of-pocket costs. AARP opposes the imposition of a new 20% home health coinsurance because:

- In effect, this new out-of-pocket payment would be a new "sick tax" on the most frail and vulnerable elderly and disabled Americans -- those who can **least afford it**.

- The new coinsurance would be unaffordable for most of the frail, lower income seniors who need these services. Almost **80%** of all Medicare home health users have annual incomes of **less than $15,000**. Approximately 24% have incomes between 100% and 150% of the federal poverty line (almost one million beneficiaries in 2002). Most of these vulnerable older Americans would no longer be able to afford these valuable services.

- For the average Medicare home health user, a new 20% coinsurance would require them to pay an additional $1,300 out-of-pocket in 2002. The coinsurance amount for approximately 740,000 Medicare beneficiaries would be **over $4,200** in 2002. This latter group are the very frail individuals who need and use home health care the most, primarily lower income older women.

- Home health users with incomes above 100% of poverty ($7,360 for singles and $9,840 for couples in 1994) would be required to pay a proposed coinsurance. Under the QMB program, the state and federal governments would pay the coinsurance for those with income below these amounts. In reality, the QMB program provides inadequate protection even for those who are eligible, due to inadequate outreach and states' difficulty paying for such an "unfunded mandate." Moreover, new unfunded mandates legislation raise questions about whether states would be required to cover new costs for the QMB population at all.

- The proposal is penny wise and pound foolish because many beneficiaries who could not afford the coinsurance and failed to receive needed services would be forced into nursing homes or hospitals. Those who could afford the new coinsurance would also spend down onto Medicaid more quickly. State and federal governments would likely end up having to spend much more than they would without the new coinsurance.

Before instituting such a regressive tax under the guise of reducing illusory, unproven overutilization, we hope that the members of this subcommittee will thoroughly explore alternative methods for improving program efficiency that will not inflict such great harm on the oldest, most vulnerable members of our society.

CONCLUSION

Medicare is an extremely successful and popular program that provides essential services for older and disabled Americans. Administration of the program has been more efficient than many think and costs have also been effectively contained, although improvements can be made in both of these areas. Medicare home health and SNF growth rates raise legitimate, serious questions about the operation and administration of these important sub-acute benefits. We would be pleased to work with members of the subcommittee to discuss mechanisms for improving the efficiency and cost effectiveness of the Medicare program.

Chairman THOMAS. Thank you very much, Mr. Lehrmann.

Mrs. Johnson from Connecticut will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I appreciate your testimony today, but I hope that in the next few months, you will think far more aggressively about how we deal with the problems in front of us.

Mr. Willging, for example, we have devoted enormous resources to trying to weed out fraud and abuse in the medical equipment area and then you see a television investigative report about back braces. I don't know how government can prevent a creative private sector from calling up people and saying, do you have back pain, Medicare covers this, can't we send it to you, and then sending them the $50 version of the back brace or $150, whatever it was, instead of the $10 elastic belt.

I don't see how you can do that through Washington. I think you can do that through integrated systems of care, and I share, Ms. Suther, your concern about HCFA's study of home health and their efforts to adjust for case mix. Our experience in the past is that they cannot adequately adjust for case mix, and if you go to a capitated payment without doing that, the person who is going to be hurt is that isolated senior citizen who has no way of getting some help if they get the wrong service or if the service is denied or tailed off inappropriately because the agency has had a capitated payment.

So I really think we ought to be far more aggressive and creative about how are we going to look at volume and appropriateness through better integration of services at the frontline level.

I do want to pursue specifically though something that is currently going on in HCFA, and that is their decision to require physicians, and I have just gotten one constituent letter about this, but I want to put it on the record and I want to get your response because it is relevant to what we are doing, to document every lab test they require over a base number, I think it is 12. Now, this is a proposed regulation.

Now, particularly for the elderly, and this is the letter I got from a doctor who deals with a lot of people between 85 and 95 who come in feeling tired, well, the problem of documenting those panels, from the point of view of quality of care and also efficiency, this is certainly no way to manage our problem, and if you can shed any insight on what you think we can do better to manage the costs of testing as opposed to this kind of arbitrary bundling and heavily regulatory and redtape oriented solution, I would be happy to hear your comments, Dr. Sundwall.

Dr. SUNDWALL. I appreciate your raising that. I had an opportunity to testify before the Practicing Physicians' Advisory Committee that HCFA convenes periodically and that was especially to comment on this very kind of proposal.

I am a physician and I see patients, and I can't begin to tell you how silly it is, in my mind, to go backward by requiring more paperwork, not less. If I had to sit and write a paragraph about every test beyond the 12 channel that I need to take care of the patients I see, it would add hours to my paperwork, and I don't know how many reams of paper itself.

I think there is a better way and one thing that we have recommended to HCFA is simply to have on requisition forms an attestation, a signature by the physician, that the tests ordered are needed. The physician should be able to determine on a case-by-case basis, considering the patient's clinical condition, and "attest" that the tests ordered are needed for diagnostic and management purposes.

I just don't think we could afford enough regulators to go in and review charts and second guess doctors' judgments. Laboratory data is valuable in making judgments about patients' care, whether they are on medication, whether you are trying to make a diagnosis, or to initiate some preventive service. ACLA's simplest solution to HCFA's perception of need to document necessity was an attestation, some indication that the lab could keep on file. However, we don't think it necessary nor appropriate for HCFA or lab personnel to go into doctors' offices and do more reviews.

Mrs. JOHNSON. The final irony is they will pay physicians $15 for this battery and hospitals $40 for this battery, and it just reminds you that somehow we have to push this system down to the docks and the patients again if we are going to restore access to quality care and control cost.

Any of you who want to get back to us further on thoughts about how we can better integrate care are welcome to do so. We simply have to take a giant step. You recommended some solid baby steps and I appreciate that. In the short term this year, we will certainly need that, but we have to really reverse the terrible trend that was evidenced by this recent ruling by HCFA.

Thank you.

Chairman THOMAS. Gentlewoman's time has expired.

Gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Sundwall, let's talk about this issue of 20-percent copay for clinical labs. The argument that you make that some of these claims are so small that it costs more to try to collect than the copay you get in is, I think, one for us to look at, and consider. Can you help us with that? Is there a way that we can avoid that problem and yet institute the discipline of the 20-percent copayment on larger claims?

Dr. SUNDWALL. Well, I think that on larger claims, there is an incentive to go after that. We have done some very preliminary analyses (or some of our members have) and the impression is that the administrative costs required to submit those bills, the cost of sending out letters, and then the predictable percentage of nonpayment of the bills sent, means it just wouldn't be in our economic interest to collect the copayment. Coinsurance would simply amount to an additional cut, a cut in payment for lab services.

If there is a copayment that is of sufficient size for someone to go after, it pays for them to invest in the administrative cost to collect it. I think there are other ways to get efficiencies and to make sure there is appropriate use of laboratory services, and those are the things that we are working on with HCFA. I personally believe clinical practice guidelines will help ensure that doctors are only ordering the kinds of tests that are going to be necessary and useful in the patient care.

Mr. McCrery. Well, do you not see any value in putting at least a portion of the cost on the consumer when it comes to controlling utilization and getting the consumer more involved?

Dr. Sundwall. Not when it comes to lab tests. Let me explain. When you are a consumer and you are making a choice about buying something, then it makes a difference. But when you are a patient going to a doctor, I don't think you have much interest in nor an informed perspective about what kind of lab services your doctor orders on your behalf.

It would be the unusual patient, I think, that would engage the doctor in a discussion saying, well, now, do you really need to order that lab test on me because I might have to pay $2 or $3 in addition to what you are going to charge me?

I think that there are instances when a patient really wants that kind of participation, but when a physician believes they need electrolytes tested, or a complete blood count, or a pap smear, I don't think most patients are going to want to talk them out of it in order to save some money.

Mr. McCrery. Well, again, I am of the opinion that we need to get the consumer—the patient—more involved, and perhaps if we couple medical malpractice reform with a copayment reform, then we will get a better interchange between the physician and the patient; that dialog will take place more often, because you are right, in today's marketplace, it doesn't take place very much at all, if at all. Anything that you can come up with to help us solve your objection about the small claims—which I think is valid. For those of us who want to get the patient more involved in the decisionmaking and in controlling costs generally—would be appreciated.

Dr. Sundwall. I appreciate the invitation and I will be glad to get back to you with some ideas.

[No information was received at the time of printing.]

Mr. McCrery. Thank you.

Thank you very much, Mr. Chairman.

Chairman Thomas. Mr. Christensen.

Mr. Christensen. Thank you, Mr. Chairman.

Mr. Willging, I wanted to ask you, looking at your chart over there, comparing the skilled nursing facility with a hospital, how much of the health care dollar can be saved by utilizing a skilled nursing facility versus a hospital?

Mr. Willging. In this particular area called subacute, Congressman Christensen, that is, services traditionally provided only in the hospital which can be, we now find, provided in a subacute unit in a skilled nursing facility, not all skilled nursing facilities, but those that have geared themselves to subacute, there is a potential savings of up to $9 billion per year. Abt Associates did a study which took 62 DRGs and put together panels of clinicians asking themselves how many of these DRGs really require, as the law specifies, 3 prior days in a hospital before one can move that patient into a subacute unit in an independent nursing facility. They found five DRGs required no hospitalization at all and that would be an automatic savings of $500 million per year if patients were allowed to be admitted directly into a nursing facility.

Of the other 57, they found that most of them did require a hospital stay to stabilize the patient, but that stay required only a day or two and that they could then be moved immediately into these subacute units. Now, when we are talking about a subacute unit providing the same day of care at commensurate levels of quality for one-third to one-half of the comparable day in a hospital, we are beginning to talk about big bucks and the potential is $9 billion per year, even if you subtract the costs to the hospital of keeping a bed vacant, you are still talking about $7.5 billion per year. Now, that is on the outside, but that is a lot of money.

Mr. CHRISTENSEN. I would be interested in looking at that report. You say that is a study?

Mr. WILLGING. It was completed about 6 months ago. We would be happy to supply one to you, sir.

[Due to its size, the information is being held in the committee files.]

Mr. CHRISTENSEN. Besides the $7.5 to $9 billion that you have just talked about, what other proposals might your industry have for the committee in terms of streamlining Medicare and making it more efficient and saving some dollars?

Mr. WILLGING. Certainly if you want to move beyond the concept of managed care and the use of subacute, which is the big one, there are still numerous others that we have been working with this committee and the Senate on, the development of a prospective reimbursement system, for example, for the SNF benefit.

While hospitals moved to protective reimbursement 12 years ago, the Medicare program still pays on a cost reimbursement system. One, it is inefficient. Two, it doesn't provide flexibility to be able to adapt to the varying needs of the residents, and three, it provides no predictability whatsoever.

We think that is extremely important. There are some arcane provisions in the law which none of us really understand where they came from. For example, a nursing facility may not hire respiratory therapists. We are not sure why. We can hire physical therapists, occupational therapists, speech therapists, but we may not hire respiratory therapists, so if a nursing facility needs to put respiratory therapists on them, it needs to hire them through a hospital with the inevitable billing that the hospital then adds on to the total.

Those are the kinds of fairly obscure regulations that if eliminated would bring immediate cost savings.

Mr. CHRISTENSEN. I wish the members of the last panel were here. I wanted to hear their comments regarding what you just said just to see if they are in agreement or if there is contrary opinion.

Dr. Sundwall, would you have an opinion on those two questions or not, what he has just stated?

Dr. SUNDWALL. Well, I think that, as you have implied, we have to look at a new way of doing business. When it comes to laboratory work, I think the greatest promise really does lie in getting consensus on what is necessary for every stage of a person's life for preventive health or for disease management. That is why clinical guideline development and outcomes research are so important.

But I do want to make a point, and this may sound self-serving, but I don't think there is a whole lot of lab work that is done that is not needed. If you are a patient, you don't want your doctor flying blind, that is, without information about your body or your health. Lab services are a bargain. They give you a bunch of information about your metabolism, what disease process might be going on, so we don't want to discourage that. What we need to do is make certain that what is ordered is needed.

Under Medicare, I don't think we see overutilization of lab services because we have direct payment to the lab services so the doctor doesn't have a financial incentive to order excessive testing. In fact, like I said in my testimony, where we have States where all insurers bill directly to the lab, the way Medicare requires, you get a lower utilization of lab services because there is no incentive economically to do more than the physician feels like they need. So those are the things I think we need to look at.

Mr. CHRISTENSEN. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from New York, Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

I would like to ask a couple of questions. The first one involves technology. Mr. Lehrmann talked about the use of technology, advances in technology in his paper, and yet it seems to me that there is some problem here in some of the working out of the payment schedule, because, you know, it has been urged that new technologies drive down the costs associated with many tests, and I have known this particular instance, I won't give you a litany of those, and yet HCFA for many years pays the costs associated with the old technologies, and I want to know how you feel about that. Now, that is question number one.

The other question is, it doesn't seem in any of the testimony, and maybe even in our questions, that we are really getting at the basis of the incentive to close the gap between the people who pay and the people who receive, and would there be a possibility of considering, and this is a little bit off the wall here, but I ask you, since you are the experts here, to create a system where we could give people a sufficient amount of money to cover them under normal circumstances, just outright, pare that down so it is reasonable, and yet at the same time have on top of that a catastrophic plan so they will not fall off the cliff, any way to create an incentive to pull the costs back and have the people who were involved in receiving the treatment be part of the system?

So those are two questions. Maybe you can—any of you that would like to answer those.

Dr. SUNDWALL. Let me take a crack at the first one. I really think there is a problem with continuing to pay for technologies which may not necessarily be outdated or outmoded, but that have been improved upon.

It seems as though we keep doing additive reimbursement for medical services, whether it be for imaging or various kinds of care. I think that the committee and HCFA might gain some significant savings if they would reimburse only for the most effective technologies without paying for every component of stepwise or additive technologies.

Mr. WILLGING. Let me take a crack at the second. Then I will probably do it in terms of a personal viewpoint rather than representing any particular industry.

I think one of our problems, and this has bedeviled me for years and I have spent 25 years in this town worrying about health care, health care costs, including a stint as Deputy Administrator at HCFA, and the more we have removed the individual, the consumer, the purchaser, and I think this gets to Congressman McCrery's comments about copayment and coinsurance. The more we remove the purchaser from the financial implication of his or her choices for health care services, the more we see the dramatic cost increases we have seen over the past 10, 15, 20 years.

And if one could develop a system, sir, whereby the government is there for some of the major catastrophic events, but relying perhaps a little bit more on the individual consumer or purchaser, and that may be the business, that may be the individual himself or herself, I think we may have a better system.

I do believe strongly that financial incentives are the most critical and impelling incentives we have. And as we take away from the individual who buys the service, who makes the decision, the incentive or the disincentive, I think we find ourselves in the dilemma we are in today.

Ms. SUTHER. I would like to address that also, sir.

I think in the health care industry, we are quite different from all the other industries in the country, or at least the efficient ones, and that is, form follows function in every industry except ours and in government, and in health care, form follows reimbursement, and I think that we have to look at things in a more basic way and look at form following function as opposed to following reimbursement and start over with that system, and again, that is my own opinion, not that of NAHC.

I think that can be done through incentives, both to providers and incentives to users of services.

Mr. HOUGHTON. Mr. Lehrmann, do you have any comments?

Mr. LEHRMANN. Well, one has to look at the program as far as Medicare is concerned. In the first place, why was it devised? Because costs were outstripping what older persons could afford back in 1965, so we reached the point at that time to try and devise a system to put everybody under the umbrella, those over 65 and those that were disabled. I believe it is a system that has been effective over the years.

I think perhaps if there are factors that relate to costs that we are trying to get at, then we ought to look at ways of functioning within the health system for all persons that will bring this to reality.

There are some adjustments that could be made and we certainly think that we could look at some of those as ways of improving the system.

However, to move from that system to a broader approach where you involve individuals, I would have to raise some share of concern because we are dealing with many very elderly people who have limited ability to make decisions, the kind of decisions you are talking about. The kind of competitive arrangements we are talking about do not exist in many parts of the country, and so we have to be very careful as we take each of these steps.

We also have to take a look at it on a broad base. We have to involve the entire health care system, not just that dealing with Medicare and older persons. If we do that, then let's take a look at the whole thing.

Chairman THOMAS. Mr. Johnson of Texas.

Mr. JOHNSON. Thank you.

Ms. Suther, you talked about how home health care was a tough nut to crack, I guess, and my question is, with all the discussion we have had today, the Florida incident that the IG talked about and the lack of coverage on certain items in areas, is the mandate of Medicare such that it is not sufficiently flexible to take care of new innovations and/or does everybody out there understand when they are filling out the piece of paper to get reimbursed what they are doing? Is there as much fraud out there as they are trying to make believe, or is it that some of the people just don't understand the system when they are filing returns?

Ms. SUTHER. I think it is both. I think there are those that do not understand the system. There are some States that do not have sufficient criteria for running a home health agency and in those States people just simply don't understand the system. I think there is a fair degree of flexibility, and I think that the paperwork has been reduced more in the last couple years than it had in the previous 20.

I think that there is fraud out there. I think it is a minority of providers that are providing fraudulent services. Unfortunately, some of them are large. And unfortunately, the IG's office has not had the manpower to follow up on that. And to that end, our association has been recommending a private right of action under Federal antikickback laws to supplement the limited resources of government enforcement agencies so that in the event that we know of fraud in the industry, we can report that to a private enforcement agency and go against it, because right now if I know of a State case of fraud, I can call the State Medicaid office and that gets taken care of. It gets taken care of immediately. But if I call the IG's office that may not happen, there is so much out there, unless it is an awful lot of fraud, they don't have the manpower to take care of it.

Mr. JOHNSON. Or there is no response from the Federal agency?

Ms. SUTHER. They respond. They just simply don't have the manpower—they put it on a waiting list.

Mr. JOHNSON. How much contact do you have with the IG in HCFA?

Ms. SUTHER. I have contact with HCFA through the association. I chair the Prospective Pay Reimbursement Committee and have worked with HCFA very closely since its inception, even back to the old Social Security Agency and they have been very responsive to the degree that they can respond. HCFA has, within the law, they have been extremely responsive.

Mr. JOHNSON. Are you suggesting that the State is doing a better job than the Federal Government because they have more people? Is that what you are saying? Or are you suggesting that the Federal Government could turn it over to the States?

Ms. SUTHER. Neither. I am suggesting that in Medicaid home care, which is only 1 percent of the budget in the State of Texas, so it is very rare that I would find a case. So that the one case that I may find, there is staff to take care of it.

Mr. JOHNSON. They investigate those homes a lot and have run into some problems with some of them, the elderly care homes.

Ms. SUTHER. In the home care, we don't have but 1 percent of the budget, though.

Mr. JOHNSON. I understand. That is different from what we are talking about.

Ms. SUTHER. Right. And the other thing that could be done, I think is prospective pay. If done properly, that could eliminate abuses and some fraudulent activities as well.

And it is not that we aren't happy that HCFA is doing this study. There are some things that need to happen to that study to make it predictive of cost, because it doesn't make any difference unless you know what makes a difference in cost, it doesn't do any good to come up with a very elaborate regression analysis.

Mr. JOHNSON. Do you find the doctors responsive to you in the home health?

Ms. SUTHER. Very responsive.

Mr. JOHNSON. OK, thank you very much.

Thank, you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Johnson.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me thank all the witnesses for their testimony. I first want to mention to Mr. Doherty in regards to your efforts and your organization's efforts to curb fraud and abuse, we appreciate very much the suggestions that you brought forward in prior Congresses, and we hope that you will continue to bring forward suggestions from your industry in this area. It has been helpful to us before and I personally thank you for the working relationship that we have had in this area and hope that we will continue it in this Congress.

Mr. Willging, I have a question on the 3-day rule. I have noticed in your written statement that you comment that there are potential cost savings to Medicare if we could have waived the 3-day rule. I have been very interested in this issue. We had some matters put in the last bill that started to go through our committee to start a pilot program in this area. I am just curious as to how much savings you believe we could gain for Medicare if we don't have the 3-day rule requiring the patient first to go into a hospital setting.

Mr. WILLGING. Well, it has been a long saga, as you know, Congressman Cardin, the 3-day rule. It has been our actuaries vis-a-vis CBO's actuaries as to whether one should eliminate the entire 3-day rule.

We argue it would save countless billions and the CBO argued it would cost countless billions, so we learned our lesson and got off of saying eliminate the entire 3-day rule. Rather we sat down and said, let's take a look at just those DRGs which are more appropriately served in the subacute unit in a nursing facility with no 3-day stay or at least less than the 3-day stay, and as I indicated in prior testimony, there is a potential there for up to, I emphasize the up to, I don't want to make promises that can't be fulfilled in terms of those total dollars, but $9 billion per year.

When it was enacted in 1966, I am sure the 3-day rule was appropriate, for whatever reason. But as technology has changed and as we recognize that more and more services heretofore provided in the hospital and capable only of being provided in the hospital can now be handled quite easily, not just in the skilled nursing facility, but in home care as well. A ventilator-dependent patient is a very good example. We concentrate more perhaps on the geriatric ventilator. Home care does well with the geriatric patient. These are at-home remedies required given the current state of health care delivery, and yes, there are lots of dollars that can be saved by eliminating, at least selectively, the 3-day rule.

Interestingly enough, that does not require legislation. The Secretary of the Department of Health and Human Services has the authority today to immediately waive all of or at least selectively the 3-day rule.

Mr. CARDIN. I have written the administrator a letter urging him to move forward on at least some pilot demonstrations. I agree with you, I think there are tremendous savings here.

It just doesn't make sense to impose this requirement where you can receive the care in a less restrictive environment that is going to save money and it is going to be better for the patient. We should at least be willing to experiment and move forward in this area, and I thank you for your great help in that matter.

Mr. WILLGING. We thank you for your help too, Mr. Cardin.

Chairman THOMAS. I too want to thank the panel. I think it is the clear understanding that what we need to move into is more of a seamless continuum of care.

Technology has allowed us to do a number of things for individuals in the home or in a less costly facility than we have in the past. We simply haven't availed ourselves of it, and Dr. Sundwall, I hope that the water doesn't rise too much higher before we can make sure that it doesn't rise at all in terms of a change in the structure.

The point that you folks didn't stress that I think we need to talk about, and clearly we are talking about dollars and cents, and this is the Ways and Means Committee, and we are looking for ways to save money in the system, but we need to refocus our attention on the individuals who are receiving the services as well, and that is that there is a quality aspect here, if we can sort out the funding situation on that continuum of care, in which people are receiving better care in places that are more meaningful to them, hopefully more and more in the home.

One of the things that I think all of us have to understand, Mr. Lehrmann, and I appreciate your testimony, we are faced with a part A hospital trust fund that is now contemplated going broke in 2003. We have removed all of the limits off of salaries and wages. We now tax all of the money that people make in this program, and that we are now going to have to focus, if we are going to get more money, on increasing tax rates, and that is people who are working that are paying for that.

On the part B, as you know, 75 cents out of every dollar comes from the general fund, taxpayers paying into the general fund.

Medicare, as you in your testimony focused back on in the midsixties, I believe anticipated a 50/50 split between the beneficiary and government. It is now at 75 cents on the dollar paid for by the general fund.

All of us are concerned about those folks at the lower end of the income, the 100 or the 150 percent of poverty level, or the 200 percent of poverty level, but I think by the time you reach 1,000 percent of the poverty level, or 1 million percent of the poverty level, that we ought to begin talking about perhaps this isn't the best allocation of the taxpayers' dollar for people who can clearly take care of themselves.

But the failure to focus on where the money is being spent and who it is being spent on by virtue of arguing about widows at home on SSI, I think, has allowed us a misallocation of resources, and I hope you will join with us as we go forward in trying to rethink this program that we are going to do it with sympathy and understanding, but changes are going to have to be made, otherwise we are looking at a bankrupt program, and more and more dollars from the general fund going to millionaires in retirement, and I think you will agree that is wrong.

Mr. LEHRMANN. I understand what you are saying and I think that in the process of looking it over, we have to see where all of this fits into the overall picture in terms of how much those individuals paid in initially into the program while they were still being employed, and then what they are paying in now in terms of the taxes that they pay to support the program.

So we are familiar with that and that is what we have to take into consideration.

Chairman THOMAS. And as we move forward in integrating the program, I think the Tax Committee, Ways and Means Committee, can play a vigorous role in beginning to blend what clearly now are supposedly separate views, that is, medical care for the elderly, a lot of the long-term care for the elderly is not really medical.

We are moving in the Contract With America some changes in terms of insurance policy, but there are so many categories for dealing with these and methods of funding that it is, I think, Mr. Houghton said in the middle of it, it is a very complex and difficult area to get your arms around.

We need to do it because of the funding, but I think fundamentally and more importantly, we need to do it to make sure that folks who deserve these kinds of services aren't in fear of losing them.

We believe, as you do, there are models in the private sector that will give us some examples. In the area of fraud, I believe all of us believe we are dealing with not just a minority, a significant percentage of the minority, and our job is to make sure that those people don't define the field for us, and I want to thank all of you for your testimony and look forward to working with you as we try to move legislative solutions to these common problems.

Thank you very much for your attendance.

[Whereupon, at 2:27 p.m., the hearing was adjourned to reconvene on Tuesday, February 7, 1995 at 2 p.m.]

INCOME RELATING THE PART B PREMIUM OF MEDICARE

TUESDAY, FEBRUARY 7, 1995

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:08 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

Chairman Thomas. The Health Subcommittee will come to order, please.

Today, the Health Subcommittee continues its examination of Medicare policy with today's hearing on income relating the part B premium. The subcommittee's task is to answer two questions: One, should taxpayers who now fund more than three-quarters of the cost of Medicare part B benefits through the general fund revenues subsidize other Americans who can well afford to pay more of the tab for their own care. And if the Congress should relate part B premiums to income, what are the design issues raised for such a change in the law.

Currently, almost all Americans entitled to Medicare enroll in part B. They pay a monthly premium which currently is $46.10, and receive coverage for 80 percent of the cost of physician and other outpatient services after they satisfy an annual deductible of $100.

All Medicare beneficiaries pay the same part B premium and all receive the same benefits. This is a one-size-fits-all program, without regard to the income or means of any individual enrollee. This may have made sense in 1965 when beneficiaries paid half the cost of their part B benefits and the other half came from the general fund.

However, today, $46.10 covers less than 30 percent of the per beneficiary cost of the part B, and this number will shrink to 25 cents on the dollar in 1996, and even lower after 1997. Eventually, if you carry that out, the premium payers will contribute 8 cents or less on the dollar to the cost of their part B benefits, and the taxpayers of the future, our children and grandchildren, will have to pick up the rest, if they can.

Furthermore, Medicare part B has grown by 26 percent since 1980, and it will cost more than $205 billion by 2005 or almost 2 percent of the Nation's entire gross domestic product.

Medicare part B, despite the cost sharing with the beneficiaries, is a major contributor to the deficit and, therefore, without changes, a major impediment to balancing the Federal budget in the next 7 years.

It is also worth underscoring that the financing of Medicare part B is fundamentally different from the funding of Medicare part A. With few exceptions, Americans earn the right through the payroll taxes they pay to draw on the part A trust fund when they reach 65. So part A is an entitlement we earn during our working years for the right to participate in part A.

Part B, however, is a privilege subsidized heavily by the nonelderly taxpayers for the elderly. The public, it seems, also senses the need for the well-to-do elderly to pay a greater share of the cost of Medicare. A Kaiser Foundation-Harvard 1994 post-election survey reports that fully 71 percent of the voters in the last election support "having people over 65 who earn more than $50,000 a year pay more for Medicare than other seniors." Interestingly, the result showed those who voted for Democrats in House races felt even stronger about income relating Medicare than did Republicans.

In light of these facts, this subcommittee must address reforming the finance policy of Medicare part B. Of course, in reform of the financing of part B, we should not add to the burden of elderly Americans who live from Social Security check to Social Security check with a fixed income from whatever savings and modest pension they may have accumulated.

Nevertheless, the framers of Medicare did not envision that the part B benefits would be such a huge drain on the general fund or that the average taxpayer would be expected to foot the bill for such a large share of the costs of care for well-to-do Americans.

President Clinton recognized the need to address this issue last year in recommending in his budget and health reform plan the income relating of part B. Members of both the House and the Senate also introduced legislation in the 103d Congress which would have limited the taxpayer subsidy for part B for those well-to-do elderly enrolled in Medicare. It is time to consider these proposals again.

The President has been supportive of income relating part B. However, in the President's most recent budget, there was a reluctance to exhibit any kind of leadership role on new or novel plans. Secretary Rubin said in front of the full Ways and Means Committee this morning that, despite no specific proposals, the President wanted to be partners with the Congress. My feeling was that partners was similar to my wife and I in moving furniture, that is, she wants me to do the heavy lifting and she will tell me where to put it.

Congressional Republicans and Democrats have supported means testing. Today we will hear testimony which indicates why it is important and how best to structure this new Medicare financing policy. Today's hearing offers an opportunity to revisit this reform.

It is important to emphasize, however, that if we income relate part B, it is only an incremental step in Medicare reform. It is no more than a downpayment on the transformation of Medicare, which is our mandate for this year.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I take to heart your remarks about the President's lack of direction, but at least he was going in one direction, unlike the Republican proposal before us, which takes us in two or three directions at the same time. And if it does not utterly confuse my colleagues in the Legislature, it will drive the senior citizens in this country nuts trying to figure out what we are doing.

I will tell you very quickly a story. I am not sure as to its truth, but it describes the point I am about to make. It is a story of the shipyard workers of Mare Island in Vallejo, Calif., who were working on both ends of a submarine tied up at the docks at Mare Island. They like to have it level so that their coffee did not spill. One of the welders in the front would let a little water in the ballast, and they would go to lunch and somebody in the back end would let a little water in the ballast. After 2 or 3 weeks, the last guy let a little water in the ballast and the whole submarine sank.

That is exactly what the Republicans are doing here as they fiddle and faddle with Social Security. Now, we have heard that it is part of the Contract to lower the tax on Social Security benefits from 85 percent to 50 percent on the wealthier Social Security beneficiaries. A great idea. My mother is all for it. I shortly will be all for it.

On the other hand, as we giveth with the left hand, we are now having a hearing today to take away from exactly this same group money by raising their Medicare part B premium. I will give you an example from this committee's minority—the Republicans of last year in their program in the health reform package. If you had a couple with $120,000 a year, we would decrease under the Republican proposal this year their income tax by $1,400 and increase their part B premiums by $1,650.

Now, I ask you, does that make any sense? Could we not just deal with one or the other and not raise or lower? And the real sad effect is this: The amount we lower the Social Security tax by, if we repeal the 1990 act, if that is what it was, comes out of the Health Insurance Trust Fund part A, and everybody is complaining, most loudly Mr. Gingrich, that Medicare is going broke. He takes the money out of the trust fund when he cuts the tax on part A, and then raises the tax on part B and that goes to the Treasury and not into the trust fund.

I would suggest that we wipe the slate clean and start over. If our intention is to lower the taxes for the richest of the rich in Social Security, let us do it. If our intention is to punish them and raise their Medicare premiums, let us do that. But for heavens sake, let us not compound what Rush Limbaugh already tells the public that we do not know what in hell we are doing and that we are raising taxes on one end, lowering taxes on the other, and speeding the bankruptcy of the Medicare trust fund. It makes no sense.

Mr. KLECZKA. Would the gentleman yield?

Mr. STARK. I would be glad to yield.

Mr. KLECZKA. I just wanted to make a comment on the Chairman's contention that the President is not being a partner in deficit reduction and is not looking for ways to cut back on the deficit.

I recall that about a year and a half ago the President brought in a very bold plan before Congress. It was Republicans who left the room and left all the heavy lifting of the couches to the Democrats and the President. Now that they own the home, they want us to continue the heavy lifting while they still take a walk. No deal, Mr. Thomas.

Mr. STARK. Reclaiming my time, I just want to say that I could support—and we are about to hear from my former colleague on this committee, the distinguished Senator from New Hampshire who I think was the originator of the idea of income relating the premiums in the catastrophic bill of such great fame.

Now, we could do that again, or we could cut taxes for Social Security. I am just suggesting, Mr. Chairman, let us make up our minds which we are going to do and get it straightened out and not confuse the American public, and certainly not confuse the seniors, and hopefully not this Member of Congress.

Thank you.

Chairman THOMAS. I appreciate the ranking member's willingness and commitment to move forward together.

I would tell the Senators in front of us that we have just had our second bell. If you will indulge us, we will run over and vote and be right back. Senator Kerrey, the Congressman from your State would very much like to participate in the introduction. Senator Gregg, if you will bear with us, we will be right back.

[Recess.]

Chairman THOMAS. The subcommittee will be in order.

Our first panel consists of Senator Judd Gregg, the former Governor of New Hampshire, as well as Senator, but, more importantly, a former member of this committee and a seatmate of mine, and Senator Kerrey from Nebraska.

Before I turn to my colleague for the introduction of Senator Kerrey, I want to thank you in terms of your time and commitment on the Kerrey-Danforth Commission. You thought thoughts that absolutely needed to be thought. More importantly, a lot of people are thinking you folks verbalized them and tried to do something about it.

But for a more personal and knowing introduction, I will turn to my colleague from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Welcome, Senator Kerrey. I appreciate your testimony today and I wanted to extend a personal invitation to you. As the former Governor of Nebraska and as U.S. Senator from Nebraska, you have always been in the forefront on health care reform. As a businessman from Nebraska, you understand the problems that employers face in providing quality health care for their employees.

As the Chairman stated, recently you headed up the Kerrey-Danforth Bipartisan Commission on Entitlement Reform. You heard countless hours of testimony on the challenges this country and this committee faces in terms of transforming the issue of Medicare.

While we do not always agree on the solution or the method, I know we both have the interests of the Nebraskans and Americans at heart, and I appreciate your work in this effort. I look forward to working with you on this issue, and I look forward to hearing your testimony today.

Senator KERREY. Thank you, Congressman.

Chairman THOMAS. Thank you.

I will tell both Senators that your written statements will be made a part of the record in their entirety, without objection, and you may proceed any way you see fit.

STATEMENT OF HON. J. ROBERT KERREY, A U.S. SENATOR FROM THE STATE OF NEBRASKA

Senator KERREY. Thank you, Mr. Chairman.

I do have a statement that, as I look at it here, more closely resembles either a doctoral thesis or the President's State of the Union Address. I do not know which one. I do not think you want to hear something that long.

Let me try, as I almost every time have been asked to speak on this, to try to describe the problem in a fashion that would stand some possibility of us coming together and taking some action.

First of all, I am pleased to be here with Senator Gregg. I do not believe that this is a problem which we are going to be able to solve, unless we begin, Republicans and Democrats coming together saying we both support Social Security, we both support Medicare, we are not talking about damaging or hurting seniors and so forth. We have got to come and put the political swords at the door, otherwise all hope is lost.

Second, what we tried to do with our commission was not so much solve a short-term problem as solve a long-term problem. Chairman Greenspan came to the commission and said a very important thing, which is that interest rates are a signal of what is going to happen in the future. They describe what the market thinks is going to happen in the future.

Senator Danforth and I heard from economists with our proposal which solves the future problems, say that if the Kerrey-Danforth legislation were to pass, if we were to change our law to solve the problem the way that we described, that interest rates, long-term interest rates would fall by at least 2 percentage points, and maybe as much as 4. And you could get economists that would come, I believe, and people who have studied monetary policy and they would come and say the same sort of thing.

The third thing is that this is a problem that can be solved by any ideological orientation. Whether you are a Liberal or a Conservative or a Moderate, it does not matter. You can still solve the problem. But you will not solve it, if you do not acknowledge the problem exists. If you start off by saying there is no problem, then there is no argument, because what you do then is you are reduced to accusing each other. I accuse Chairman Thomas of being insensitive, and Chairman Thomas accuses me of being insensitive, and we fill the air with political rhetoric.

Any ideological orientation can solve this thing. You can come and say I am for tax increases and, thus, I am going to propose a tax increase, you can say I am not for tax increases, which Senator Danforth and I did. We proposed going on the spending side. But you can come and solve this problem with any ideological orientation.

I suggest, as a consequence of that, the most important thing for us to do is to try to convince Americans that there is a problem. What I tried yesterday to do in response to the President's budget is the following, to say that the Entitlement Commission did make a recommendation. The myth in the city is that the Entitlement Commission failed to make any recommendation. That is not true.

We did make a recommendation, and the most important recommendation relevant to our discussions here today I think is that if you look at the future for 5 years, everything looks fine. If your view of the future is a 5-year window, the world looks OK. But if the view of the future is a 30-year window, it does not look OK. There you begin to see, as a consequence of demographics, not Ronald Reagan or George Bush or Bill Clinton, but demographics where we have an unprecedented—and I emphasize this, because lots of people are under the impression, well, we have had this problem in the past and we will just come in and fix it as we have in the past.

From the year 2010 to approximately 2025 or so, in roughly a little more than a decade, the number of Americans over the age of 70 will go from 14 million to 28 million. Now, that is not something we have difficulty predicting. Some say, well, you cannot predict 30 years. That is not true. That is a fact. The number of workers per retiree is going to go from 5 to 1 to 3 to 1. There is an unprecedented change on the horizon out there and it is getting closer and closer, and the longer we wait the more likely it is that we will not be able to give people an opportunity to plan.

Key in the Kerrey-Danforth proposal was that most of the changes that we recommended making, with the exception of the changes in congressional retirement which we felt were appropriate, so we could say we are leading by example, are phased in over a very long period of time. But the longer we wait, the less chance is we will be able to give people a chance to plan for the changes that we are proposing.

But unless we can get Americans to look at this long-term problem, unless we get Congress to say that our Budget Act is inadequate—our Budget Act says 5-year budgeting. Well, it is like me saying it is February 7, for the next 5 days my cash flow is pretty good, but the end of the month I have got a lot of bills coming due. Well, the same is true with us. At the end of a 25-year period, we are looking at a problem that really makes it awfully difficult for us to say that we are not hypocrites when we talk about our children and our grandchildren, if we want to ignore what is going on now.

I want to be clear about this. The testimony lays out the details of the proposal and it is almost too hot to handle the testimony, because people say, oh, my gosh, you are delaying the age, we means test part B, we put a premium on part A. I mean there are a lot of changes in here that are controversial and difficult.

We proposed to actually reduce the employee payroll tax by 1.5 percent, establishing a mandated IRA, because we think that the federally operated retirement programs, Social Security mostly, are important and valuable, but Americans need more than just that and have begun in fact to expand consideration to say we need to look at changes in ERISA and our retirement regulation and tax law, because we may have encouraged businesses to decrease the number of defined benefit programs. We are trying to make change that solves the retirement problem that people have.

But even with all those controversial changes, even with everything that we have got on here, to be clear, we do not balance the budget. All we do is balance the promise that we have on the table today. One way of describing this—and I will close—is that the U.S. Government and we on behalf of the American people operate the two largest insurance companies in the world. Social Security and Medicare are social insurance programs, and we have a fiduciary responsibility not to take a 5-year view. We would shut an insurance company down that only took a 5-year view of what their liabilities are.

We have 30 years of liabilities and more, and when you look at the 30-year liability for Social Security and Medicare, it is inescapable, it seems to me, that we begin as soon as we can politically do it, begin to make some changes in our law that bring those entitlement accounts and bring those Social Security accounts into actuarial balance so that we have intergenerational equity, so that the promises that we have on the table we know that we can reasonably keep.

I do not know if this second, third and fourth shot of trying to explain this has been any more persuasive or any more clear than I have had in the past.

Mr. Chairman and members of the committee, I appreciate your interest in this issue. I pledge to you as a Democrat that I intend to work with Republicans like Senator Gregg and Senator Simpson on the Senate side that are interested that want to try to solve this problem, because I believe there is an urgent necessity to do so. And I believe the future will reward us with a round of applause, if we do.

Thank you.

[The prepared statement follows:]

Testimony of Senator Bob Kerrey
Before the House Ways and Mean Committee, Subcommittee on Health
February 7, 1995

I appreciate the opportunity to testify today, Mr. Chairman, on the subject of income relating the Part B premium for Medicare and the broader issue of entitlement reforms.

I have supported income relating the Part B premium for Medicare as part of Kerrey/Danforth recommendations for the Bipartisan Commission on Entitlement and Tax Reform and in other legislative proposals such as the Kerrey/Brown amendment I offered last year with a bipartisan coaltion of Senators and the Mainstream Coalition health care bill. However, income relating the Part B premium for Medicare, while a good start, does not solve either the entitlement problem, the problem of rising health care costs or the more general question of access to health care services. It only gets us 3% of the way to solving our entitlement problems. We still must address the remaining 97% of the solution. Federal health spending has been increasing at annual rates averaging 10 percent or more during the past five years. According the Medicare Trustees, the Hospital Insurance, (HI) Trust Fund is projected to be insolvent by the year 2001. In the long run, spending on Medicare and Medicaid will triple as a percentage of the economy by 2030. Clearly we must make some changes in both health care and retirement entitlements.

Before discussing some of my recommended changes, let me describe what necessitates them.

The American population is aging in a way that requires us to rethink the structure of our entitlement programs. Our two largest entitlements, retirement and health care, were designed as systems in which each generation of workers would pay taxes to support the generation of retirees that preceded it. In return, each generation expects its successor in the work force to support its benefits.

The system succeeds, provided that each generation has enough children to grow up and pay the taxes that support its benefits. Mine, Mr. Chairman, did not. Today there are nearly five workers paying taxes to support each retiree; when my generation retires there will be fewer than three. And as life expectancies continue to expand, Americans will collect more in lifetime benefits.

Quite plainly the arithmetic does not compute. We will be able to support the aging population without immediate consequences for three decades because we have built a massive surplus in the Social Security Trust Fund. The closer it gets to bankruptcy, the more excruciating our choices become. Should it reach bankruptcy, our choices will be severely restrained: either slash benefits dramatically for that one retiree or raise taxes dramatically on those three workers. These numbers are not pulled from thin air; they are documented by the trustees of the Social Security and Medicare systems.

And our retirement entitlements are in much better shape than health care. However, health and retirement programs for seniors are inherently related. Therefore, it does not necessarily help seniors to "take Social Security off the table" while allowing health care costs to increase and making indiscriminate cuts in health programs. Let me also describe some dates at which crucial changes in our entitlement programs will occur.

The first is in 2001, when the Medicare hospital insurance trust fund, soaked up by an aging population and escalating health care costs, goes bankrupt.

The second is in 2008, when the Baby Boomer generation begins to retire. In a single decade beginning at that moment, our overall population will creep up by 2 percent while our retired population skyrockets 30 percent.

In 2012, spending on entitlements and interest on the national debt will consume every dollar we collect in taxes, leaving literally nothing for defense, infrastructure, law enforcement or any other function of government.

If those dates seem too distant to merit attention, consider a figure in the here and now: In Nebraska, we have about 275,000 retirees and another 275,000 children in kindergarten through the 12th grade. We spend $1.3 billion of revenue on our kids and $4.5 billion retirees. More ominous, our spending on children increases $50 million each year; our budget for retirees expands at a rate eight times that fast.

Fixing these problems and building a better future is a challenge because it requires those of us whose occupation teaches us to think in two-, four- and six-year cycles to think instead in of decades and generations. Many of the benefits of entitlement reform will take hold in our economy years after most of us leave this institution -- as will the consequences if we fail to act.

If our political cycle teaches us to think in terms of six years at the most, the myopia of our budget cycle is worse. As families across America evaluate their finances over decades, planning for education, for retirement, for health care, their government looks five years into the distance and then turns its eyes away. The most important recommendation of the Bipartisan Commission on Entitlement and Tax Reform may be the need to expand our budget cycle to include the consequences of our actions 25 and 30 years out.

The other reason entitlement reform is difficult is that entitlements are misunderstood. Politicians turn a cloudy situation downright muddy by intentionally describing entitlement programs inaccurately.

We hear it time and again: "Social Security isn't a problem. It's self-funded." Well, yes. Today Social Security is self-funded with a 12 percent tax on every working American. Tomorrow is a different story. Tomorrow 12 percent won't cut it.

We distort our health-care entitlements as well. I do not exaggerate, nor do I consider it funny, that I could have scored points in my recent re-election effort by promising to keep the federal government out of Medicare care despite the fact that we have, through Medicare, taxpayer-financed national health care for every American over the age of 65.

And while I do not accept the rhetoric of those who describe entitlement reform as a process of pain rather than an opening of opportunity, the fact remains that it is also difficult because it requires us on occasion to utter one of the most uncomfortable words spoken in this city: "No."

We have, Mr. Chairman, all the excuses we need to postpone action. Let me give a few reasons for acting today.

The first and most important is that it is relatively easy to fix the problems today; tomorrow the fixes will be draconian.

The second is that taking action today means we can fix the problems with little or no impact on current retirees.

The third is that planning for our national future today also means we can give workers today time to plan for the changes.

Understanding the problem, what do we do to fix it?

There are several options outlined in the report of our commission and I would be remiss if I did not salute those who had the courage to submit their own ideas. They had much to lose and nothing to gain by doing so.

I want to describe today some ideas laid out in this document by former Senator Jack Danforth and me.

LEADING BY EXAMPLE

We began with the premise that Congress must lead before asking the American people to accept entitlement reform. For that reason, the Kerrey-Danforth proposal would cut in half the rate at which members of Congress accrue pension benefits beginning in 1996. Also in this spirit, we would bring retirement programs for federal workers more in line with private pensions.

Other proposals offered in the spirit of putting the government's house in order first include:

- Raising the federal retirement age to 62. This proposal would gradually phase out eligibility for unreduced benefits for Federal workers before age 60. Beginning in 2000, for workers with at least five but fewer than 20 years of service, the retirement age for unreduced benefits for both CSRS and FERS would be increased by four months each year until it reaches age 62 in 2020. Workers with between 20 and 30 years of service would continue to be eligible for unreduced benefits at age 60. EFFECTIVE DATE: JANUARY 1, 2000.

- Adjust CSRS and FERS benefit formula to "high-five" pay. The benefit formula for both CSRS and FERS would be adjusted by changing the salary base from the employee's highest three consecutive years of pay to his or her highest five years. EFFECTIVE DATE: JANUARY 1, 2000.

- Reduce the rate at which military retirement benefits accrue from 3.5 percent to 2 percent of basic pay for retirees with more than 20 years of service. This proposal would reduce the addition to retirement pay for each year of service after 20 years from 3.5 percent to 2 percent per year. It would also drop the one-time increase in retirement pay at age 62 of 10 percent. It would retain the CPI-minus-1 percentage point COLA that applies until age 62 and the one-time COLA adjustment at age 62. I emphasize that this provision applies only to military personnel hired after August 1, 1986.

- Adjusts Consumer Price Index (CPI) calculation to better reflect inflation.

Mr. Chairman, this is a key provision that has spent a great deal of time in the news lately. A number of federal programs are adjusted annually based on annual increases in inflation as measured by the CPI. The CPI is based on a "market basket" of goods and services purchased by a representative urban worker. Adjusted every ten years, the current market basket was last revised in 1987, using data for the period 1982 to 1984. As a result, the CPI does not capture dynamic annual changes in the pattern of consumer preferences. In addition, the CPI may not adequately measure the consumer benefit derived from improvements in the quality of existing goods or from the introduction of new goods. A number of economists, including those in the Bureau of Labor Statistics, have expressed considerable concern that the current CPI calculation overstates inflation. This proposal would require the Bureau of Labor Statistics to modify the CPI formula to more accurately reflect changes in the cost of living. This change would take effect in 1998 and save a substantial amount by bringing annual Cost of Living Allowances better in line with inflation.

PRESERVING AND STRENGTHENING SOCIAL SECURITY

A chief goal of the Kerrey-Danforth proposal is fulfilling our promises to today's retirees while ensuring the long-term health of Social Security. I have already described the challenges that face this system.

Our proposal for redressing it is, I believe, among the most exciting in the Kerrey-Danforth plan. We propose reducing the payroll taxes of today's younger workers by 1.5 percent in exchange for a revised long-term contract. It shifts more responsibility, and control, to the individual, provides opportunity for higher returns on investment, and allows us to return Social Security to its intended purpose: as a supplement to personal retirement savings. Let me be clear: No reductions in Social Security benefits affect anyone over the age of 50 and no Social Security reductions are used to reduce the deficit. The savings we proposed to Social Security would go back into the Trust Fund and strengthen the program.

We would require these younger workers to invest the savings from the payroll tax cut in a mandatory IRA-type personal savings account.

The proposal has important economic benefits. Countries that save and invest more grow faster and have more rapid improvements in the standard of living of their citizens. Private savings in the United States have fallen from more than 8% of the economy in the 1960s, to about 5% today. The Kerrey-Danforth proposal takes an important step toward reversing this trend.

More exciting, though, is the fact that this proposal gives workers more control over planning for their own retirements by transferring authority for these investments from the government to the individual. The return on these savings provides workers the potential for far more in lifetime benefits than they can expect from the Social Security system if it continues on its current course. This is, Mr. Chairman, a middle class tax cut with both a purpose and a payoff.

We also propose, over a period of 30 years, to raise the age of eligibility for full benefits from 67 to 70 while still allowing partial benefits at age 62. This option accelerates the phase-in to age 67 that is already in current law. The age for full eligibility will reach 70 for those under age 28 today. No one currently over 50 would be affected.

Let me address a great misunderstanding about the previous two proposals. The term we use to describe the age at which Americans are eligible for full benefits -- the term, "retirement age" --is misleading. Americans do not want to retire at age 70; if anything, they want to retire earlier. They cannot do so, Mr. Chairman, they cannot mathematically do so without a substantial pool of private savings. The previous two proposals, therefore, are designed to increase the individuals' control over when they retire. Make no mistake: the age at which Americans retire is set by economics, not statute. A low statutory retirement age means nothing for those who lack the savings to enjoy it.

Our other proposals to restore solvency to Social Security include:

- Including State & local workers in Social Security program. Starting in 2000, new workers and those with five or fewer years of service would be required to participate in the Social Security program.

- Indexes the Social Security "bend points" for CPI instead of average wage growth. Effective for new recipients only, beginning in 1998, this proposal would index the "bend points" in the benefit formula for inflation as measured by CPI instead of adjusting them for average wage growth. This proposal would adjust the benefit formula to more accurately reflect inflation.

- Reduces growth of benefits to mid and upper wage workers using the 3rd bend point. This proposal would modify the benefit formula over a 50-year period beginning in 2002, gradually reducing the growth in benefits paid to workers with average and above average earnings. No person age 55 or older would be affected, and in the first two decades after it takes effect, the impact would be minimal. EFFECTIVE DATE: JANUARY 1, 2002.

- Adjusts CPI formula to better reflect inflation.

HEALTH CARE AND OTHER ENTITLEMENTS

Many critics who oppose reforms of Medicare point, correctly, to the fact that much of the increases in this program are due to escalating health care costs. This concern ignores at great peril the fact that in addition to higher health care costs, our health care entitlements are growing because more Americans are retiring and taking advantage of them. The fact is that Medicare spending will continue to skyrocket due to an aging population even if the growth in health care costs is -- in what would be a certifiable miracle -- held to the rate of inflation. To address the escalating health care costs, we propose giving retirees the option of using the funds they would normally receive in Medicare compensation to enter managed-care programs that provide incentives to control costs and may provide better coverage. This would give seniors more options and would insert market incentives into the systems.

The Kerrey-Danforth proposal also fairly and evenly controls the growth of all entitlement programs by doing the following:

- Use adjusted CPI to better reflect inflation. The same proposal described above would apply to veterans' compensation.

- Means test Medicare, veterans compensation & unemployment insurance. This option would be phased in over five years, starting in 2000. The sum of income from government payments, earned income, and unearned income would determine the rate of benefit reduction for these three programs. The option would gradually reduce benefits for families with incomes over certain thresholds. For example, reductions would start at 10 cents for each additional dollar of income between $40,000 and $50,000; rise to 20 cents for each additional dollar of income between $50,000 and $60,000; and increase thereafter up to 85 cents for each additional dollar of income above $120,000. Regardless of income level, all beneficiaries would continue to receive a benefit, albeit reduced for those with less need. This proposal, I believe, is both fair and necessary.

- Cut other entitlements by 10% in 2000 and cap their growth accounting only for inflation and population growth thereafter. This option would require a 10 percent reduction in all other entitlements from the 1999 level of spending -- about a $20 billion cut). Programs affected include Food Stamps, AFDC, veterans pensions and compensation, farm price supports, and unemployment compensation. EFFECTIVE DATE: FY2000.

Although Senator Danforth and I did not include a recommendation on overall health care reform, I personally believe that the eligibility for health care should be radically changed. I would prefer a system where you became eligible if you satisfied one of two things: You are either an American citizen or you are here legally. If you satisfy those two things, you are eligible immediately. You do not have to get blown up in a war as I did, you do not have to wait until you hit the age of 65 as we have with Medicare, you do not have to prove that you are poor or remain poor as we do with Medicaid, and you do not have to trust that your employer will provide you with your insurance or that you won't lose your job and find yourself without health care. We ought to simply say, if your an American or here legally, you are eligible. We also need to follow immediately and say that the only way I can write that contract, the New Covenant as the President describes it, is if you an individual accept the responsibility to pay according to your capacity to pay, and agree to participate in a personal way in cost control. If you do not agree with those two things, then we can't write the contract. But if you agree to do those two things, then I think we can dramatically and radically alter the way we have become eligible. And there is agreement by the way, between Democrats and Republicans who are approaching this issue of health care that would be a reasonable thing to do.

TAX EXPENDITURES

Mr. Chairman, I have described problems and solutions for our two largest entitlements, retirement and health care. The third largest is tax expenditures. The Kerrey-Danforth plan proposes adjustments in the tax code to ensure that the code accurately reflects changes in our economy. We also propose limiting "tax entitlements" in a fashion that makes the tax code more progressive. While I regret that the Commission did not have the time to fully examine our tax code and make recommendations to simplify the code and retool it to promote savings and investment, I believe these changes are imperative and look forward to working toward this goal.

The Kerrey-Danforth plan would:

- Limit itemized deductions to 28%. Itemized deductions would be limited to a rate of 28% regardless of the marginal tax rate applicable to the taxpayer. This would only affect taxpayers whose incomes exceed $91,850. EFFECTIVE DATE: JANUARY 1, 2000.

- The readjusted CPI described above would apply to income tax brackets, standard deduction, and personal exemptions.

- Cap employer-paid health insurance deduction. This proposal, phased in over five years starting in 2000, would limit the amount of employer-paid medical insurance and medical care that may be excluded from an employee's income for income tax purposes. The cap would be based on projected average health insurance premiums.

Mr. Chairman, we offered these proposals, and I describe them today, as a starting point for discussion. I look forward to seeing them criticized, analyzed and improved. I look forward to hearing ideas from others.

The most important thing is that the debate begin in earnest today.

Thank you for giving me the opportunity to discuss the Commission's findings and my recommendations for solving the problem.

Chairman THOMAS. Thank you very much, Senator Kerrey.

Senator Gregg.

STATEMENT OF HON. JUDD GREGG, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator GREGG. First let me say what an honor it is to have a chance to speak before this committee, having served on this committee and maintaining immense respect for what you do and the work that you have, and especially the work that you have been participating in over the last month or so. It is a pleasure to have a chance also to testify before a committee which I formerly served on.

It is also a pleasure to be testifying here today with Senator Kerrey, who I have immense respect for, who has really carried a very heavy load in a rather lonely trek, which is the load of addressing entitlement spending in our Federal budget. I respect him for it for a variety of reasons.

He is obviously a hero on the physical side from his own personal experiences, but really on the political side he is even more of a hero, in my opinion. He did this while he was running for reelection. He took on the sacred cows and addressed the core issues involving questions like benefits to senior citizens under Social Security and Medicare, and he deserves an immense amount of respect for it.

The Kerrey-Danforth Commission report is an excellent report, because it defines unequivocally what the problem is, and the problem is, as Senator Kerrey has pointed out, that if we do not do something about entitlement spending and specifically about those spending accounts which involve health care in the short run and Social Security in the long run, that we as a Nation will pass to our children a bankrupt country. There is no question about it, we simply cannot afford to maintain the cost of our government, unless we address the cost increases which are driven primarily by demographics, and demographics are undeniable.

You folks are charged with the narrow band of addressing this issue, or in the hearings at least have picked a narrow band of addressing this issue and ask the question of affluence testing the premiums under part B. This has to be done, if you are going to maintain the present Medicare system.

I would like to argue in a few minutes that maybe we should take a look at a broader reform that would eliminate the part B premium altogether, but there is no question, and I think there is general consensus, and if there is any honesty and integrity, it will be passed as a piece of legislation in this Congress that high-income individuals should not be subsidized by moderate- and low-income individuals.

Why should John Jones or Mabel Smith who are working 40 or 50 hours a week at the local restaurant or on an assemblyline be subsidizing my father or the father of Congressman Stark—I am not sure if his parents are still alive, I guess his mother is—or anybody else who has got significant personal income under the part B premium process. But that is what is happening today and it is not right, it is not fair and it is not appropriate to moderate- and low-income earners that their costs of taxation, that their burden of taxation should include supporting high-income individuals.

So, yes, there clearly should be an affluence testing of the part B premium. If there is not, of course, we will see the costs that are driving this part of the budget rise from about $64 billion up to I think it is $119 billion over the next 5-year span, and that is not an acceptable number and certainly cannot be maintained.

Of course, income relating premiums does set up some questions which need to be addressed. They include, for example, what the definition of the income will be and what the mechanism for income relating the premium will be. From my standpoint, the definition of the breakpoint where you should start phasing this income in, you can look at the report of the Entitlements Commission for some very good numbers for the different breakpoints, and this committee obviously has the capacity to pick whichever one it wants.

Another proposal which the Entitlements Commission toyed with and put forward as an option is, rather than through a higher premium, to do it through taxation, so that you include in personal taxes the income benefit of the subsidized part of the premium. That is an easier way to do it. I think it probably runs into some philosophical problems, but from the standpoint of simplicity in accomplishing the effort, you can do it much more efficiently probably that way than others.

But if you are going to practically address this issue, I think you have to take a much broader approach. And I know that you as the Health Subcommittee are trying to do that. I certainly know that the Chairman is pursuing that. Rather than just looking at the part B premiums, in my opinion, we should be looking at the entire issue of how we address Medicare.

Instead of looking at it in the budgetary context, we should be looking at it in the context of how we can give a better system to our senior citizens, and at the same time potentially save some significant money, and that is doable. I recognize that has not been for years a philosophy of the Federal Government, that you can do anything better with less, but the fact is you can do significantly better with less. I know that, because I served as administrator of a State, and State governments do a great deal with less and they do it a lot better than the Federal Government does. And individuals can do even more and do it better.

So my view is that one of the attractive ways to address this issue would be to do something about replacing the entire system. As the fiscal pressures build, we here in the Congress look for more ways to slow Medicare's incredible baseline growth and for a fair way of doing this. So let us look at an approach which would basically restructure the entire system.

The approach that I would like to see us take is something which has been discussed in broad terms and it still is in the broad term of an approach, but it really is built off the concept of the Federal Employee Health Benefit Program open season approach.

In the last health care debate, we heard a lot of folks saying let's give everybody in America what Congress has. Well, certainly we could give the senior citizens what Congress has, and probably significantly improve the quality of that care or their options, anyway, and at the same time probably very significantly reduce the cost of that care, especially in the outyears.

I call this approach Choice Care. Each year we would give Medicare dollars directly to the beneficiaries through an annual capitated payment which might be called—and I think the Chairman coined this phrase—Medicheck. Is that the right phrase?

Chairman THOMAS. Yes.

Senator GREGG. Medicheck. I want to make sure I got that phrase right. The insurance plans would compete to offer the benefit at a lower rate than the capitated account level, and when they do so, the plans could then either add benefits as under the current HMO options, offer shared rebates, or a combination of both. A percentage of such rebates in the proposal we have been thinking about would return 75 percent to the beneficiary, with the remaining portion being returned to the Treasury.

A number of the managed care plans have already indicated that the opportunity for increasing market share alone would be enough for an incentive for them to compete for the Medicare risk contracts. Furthermore, the opportunity for a cash rebate would provide beneficiaries with a real incentive to move out of the old Medicare system and spend Medicare money more wisely.

We know that right now the culture of senior citizens is a fee-for-service culture, because that is what they grew up with, and that is reasonable. But if they find that their fellow senior citizens are getting a better deal, a deal that not only costs less, but which they benefit from financially, but also supplies probably more in the way of care, especially in the preventive care areas, they are going to be attracted to it. So this is an attempt to move senior citizens out of the culture of fee-for-service and into a different culture.

As suggested earlier, under this system carriers could even offer current part B premium benefits as part of a basic package which would make the monthly part B premium payment obsolete. Now, that would be a real positive event in the life of a senior citizen not to have that deduction coming out of their Social Security check, the fact that they would no longer be subject to that expenditure, the $40-plus expenditure. Our Nation's seniors would no longer see that deduction.

Importantly, while the new system would provide a meaningful incentive for people to select individualized policies, it would also be voluntary. It would preserve the current system for any Medicare beneficiary or recipient who wished to remain there, and the new system would put the individual in control and increase the coverage choices and opportunities. In my estimation, it would move individuals out of fee-for-service and into this more controlled atmosphere.

The budget process challenge to this new system is providing a guarantee to CBO that the savings will be achieved, otherwise CBO will be quite reluctant to score a voluntary system. To solve this dilemma, I believe we should consider a look ahead/look back approach. First, we would look ahead and capitate the annual Medicare payment to a rate that slows the current 10-percent growth of Medicare to an acceptable level. Second, we would also establish an annual look back process to determine if the new voluntary structure achieved expected baseline savings, and this could be a phased-in process. And if the annual goal is not reached, set an across-the-board reduction which would be instituted as required to meet the fiscal targets.

This system is just one of many options. The underlying principle, however, must be recognition that the health care system has evolved in the private marketplace. It is about time Medicare caught up. The Medicare system is a dinosaur. It is a state-of-the-art sixties health insurance program. As time goes on, Medicare's shoehorning of modern medicine into its antiquated structure becomes increasingly difficult.

Furthermore, in light of the unavoidable demographic challenges that will be pressuring the Medicare system, the Federal Government can no longer pretend to be able to serve the needs of our seniors without increasing the public/private partnership effort.

These are some of the ideas that we have been talking about on the Senate side. We expect that as we move forward there will be other ideas that will come forth. But essentially what I believe is that we must rethink the entire system, take a hard look at how we can get our seniors to have the opportunity to choose more types of care, and, in the process of choosing more types of care, be giving them an incentive to choose more cost-efficient types of care.

Again, I want to thank the committee for allowing me the opportunity to testify. I would be happy to answer questions, and I appreciate the chance to be here with Senator Kerrey.

[The prepared statement follows:]

Statement of Senator Judd Gregg

Committee on Ways and Means
Subcommittee on Health

February 7, 1995

Thank you, Mr. Chairman, for inviting me to testify today on the subject of relating the Medicare Part B premium to a person's income, a policy which I support. After explaining the reasons for my position on this issue, I would like to take a couple minutes to speak to the Medicare system in general. Relating Medicare benefits to income is important, but only to the extent that we maintain the current Medicare structure. And in my opinion it is time we restructured the Medicare system to increase choices and opportunities for seniors, and to use private sector cost-saving efficiencies.

Medicare's Supplemental Medical Insurance (SMI) System -- Part B

The time has come to adjust the Medicare Part B premium in some fashion, as a matter of both fundamental fairness, and a recognition of fiscal realities. Assuming we maintain the current Medicare structure, income-relating is one of the fairest ways to achieve needed savings.

The Congressional Budget Office (CBO) projects Part B spending to nearly double over the next five years -- from $64 billion in 1995 to about $119 billion in 2000. Because the Part B premium is set each year to collect a given percentage of program outlays, Part B recipients automatically feel the crunch of these rapidly escalating costs. The premium currently collects roughly 30 percent of program costs. Although current law allows that percentage to fall to 25 percent beginning next year, CBO still projects the premium to grow from its current rate of $46.10 per month ($553.20 per year) to $59.00 per month in 2000 ($708 per year). While that extra $150 per year may not seem like much to a wealthy retiree, it is a significant sum to many elderly persons with a fixed income above 120 percent of poverty. For those wholly dependent upon Social Security, for example, this premium increase will likely erode any benefit of the system's COLAs. As this occurs, low-income recipients will confront an erosion of disposable income.

The flip side of this, of course, is that the Federal government also confronts rapidly escalating SMI costs. While CBO projects SMI trust fund receipts to grow from $20 billion this year to $28 billion in 2000, general revenue contributions to SMI will more than double from $44 billion in 1995 to $91 billion in 2000. These figures are consistent with overall Medicare growth. In testimony before the Senate Budget Committee last week, the Congressional Budget Office stated that, "Federal entitlement spending now represents more than one-half of total federal outlays and is projected to constitute more than 60 percent by 2005." CBO also said that, "Medicare and Medicaid account for virtually all of the projected increase." As Senator Kerrey of Nebraska has explained, the problems associated with this rapid growth in federal spending only grow deeper 20 and 30 years from now. Without some adjustments, we are forfeiting our children's prosperity.

Given that some premium adjustments are necessary and likely inevitable, I believe that income relating is the fairest method. Many entitlements are already income-related, and everyone on this committee certainly knows that we also have an income-related tax code. Consequently, I believe that an income-related premium must be looked at carefully and, hopefully, adopted. These hearings are an important first step, Mr. Chairman, and you should be commended for confronting this issue head on. The President's decision to take Medicare completely off the table in this year's budget, as Medicare costs spiral out of control, is an abdication of responsibility.

Income relating premiums does raise many difficult subsidiary questions. For example, what definition of income should be used, and through what mechanism should the income-relating occur? The Entitlement Commission's staff options in this area chose a Modified

Adjusted Gross Income, which included current AGI plus tax-free interest income. The Entitlement Commission options also proposed collecting the increased premium through the tax system. Another simpler system -- which I am not advocating -- would be to base the system on Social Security income, and simply relate the Part B premium deduction to the amount of each Social Security check. These are difficult technical issues on which I know you and other members of the subcommittee understand well, Mr Chairman. I am therefore confident in this Committee's ability to work through them.

A New "Choice Care" System

Mr. Chairman, my support for income relating the Part B premium assumes that the current system will continue in its present form. In my view, however, we should be working toward a system where the Part B premium is not paid at all.

The attractiveness of relating the Part B premium to income is indicative of the problems running throughout Medicare. As fiscal pressures build, we in Congress look for more ways to slow Medicare's incredible baseline growth and for fair ways of doing so. Yet, each one of them, like income relation, brings added complexities and counter-incentives. Relating premiums to income, for example, may add on an incentive for future seniors to save less, if one result of more savings is increased cost sharing. Similar problems exist at every level of Medicare, with respect to almost every line-item change that is proposed for budget savings purposes. It is high time we began approaching changes to Medicare from the recipient perspective, not a budgetary perspective.

In my view, if we're serious about improving how Medicare works, we should move to an individualized account system that provides beneficiaries with meaningful choices, establishes incentives to save, and takes advantage of free market efficiencies. We should go back to square one, and institute a system where individuals, not bureaucracies, control the results.

The system I envision would be similar to the annual open season under FEHBP. I would call it "Choice Care." Each year, we would give Medicare dollars directly to the beneficiaries through annual capitated payments, which might be called "Choice Checks." Insurance plans would compete to offer the benefits at a rate lower than the capitated account level. When they do so, the plans could then either add benefits as under the current HMO option, or offer shared rebates, or a combination of both. A percentage of such rebates -- perhaps as much as 75 percent -- would go to the beneficiary, and the remaining portion would be returned to the Treasury. A number of managed care plans have already indicated that the opportunity for increased market share alone would be enough of an incentive for them to compete for the Medicare risk contracts. Furthermore, the opportunity for a cash rebate would provide beneficiaries with a real incentive to move out of the old Medicare system, and to spend Medicare money wisely.

As suggested earlier, under this system carriers could even offer current Part B benefits as part of a basic package, which would make the monthly Part B premium payments obsolete. Our nation's seniors would no longer see that deduction coming out of their Social Security checks. Importantly, while the new system would provide a meaningful incentive for people to select individualized policies, it would also be voluntary. It would preserve the current system for any Medicare recipient who wishes to remain there. The new system would put the individual in control, increasing coverage choices and opportunities.

The budget process challenge to this new system is providing a guarantee to CBO that savings will be achieved; otherwise, CBO will be quite reluctant to score a voluntary system. To solve this dilemma, I believe we should consider a "look-ahead, look-back" approach. First, we would look ahead and capitate the annual Medicare payments at a rate that slows the current 10 percent growth of Medicare to an acceptable level. Second, we would also establish an annual "look-back" process to determine if the new voluntary structure achieved expected baseline savings. If the annual goal is not reached, a set of across-the-board reductions would be instituted as required to meet fiscal targets.

This system is just one of many options. The underlying principle, however, must be a recognition that health care has evolved in the private marketplace, and that is about time Medicare caught up. The Medicare structure is a dinosaur -- it is a "state of the art" 1960s health insurance program. As time goes on, Medicare's shoehorning of modern medicine into its antiquated structure becomes increasingly difficult. Furthermore, in light of the unavoidable demographic challenges that will be pressuring the Medicare system, the federal government can no longer pretend to be able to serve the needs of our seniors without increased public/private partnership efforts.

As chair of a Working Group on Entitlement Reform among Senate Republicans, I can say that we in the Senate are looking closely at these issues, and considering a structure similar to the one just described. And if I read recent news accounts correctly, we seem to be settling on the same basic plan as you are in the House. The underlying concepts of the plans are very similar, as we both feel it's time our nation's seniors had the same health care choices available to other Americans. Still, Mr. Chairman, I must admit that your phraseology is more highly advanced. I have been referring to "Choice-Care," but suspect that the Senate will soon be referring to your own "Medicheck" terminology.

It's interesting but not surprising that as we grapple with the same problems on opposite sides of the Capitol, we are resolving down to similar solutions. I am sure this results from our approach being based on consistent philosophies. We both agree that the current structure, which relies on command and control, one-size-fits-all federal directives, must be changed; and we both prefer to offer more choices and to take advantage of private sector advances. Let's work together, Mr. Chairman, and get the job done.

Chairman THOMAS. I thank both of you for your testimony.

I will tell you, Senator Gregg, that we are thinking virtually along identical lines in taking an antiquated fee-for-service structure and not just trying to reinvent the formula by which we try to follow the private sector, but by creating an open system in which people through choice—and I believe your concept of the term was Choice Care—give people an opportunity to move into a system in which they can actually get more for their money than provided by the old structure, but with an assurance that if they want to stay in the old structure, they can.

That is where I would seek any guidance, because clearly the format is on the means testing, but our goal is to completely rethink the Medicare structure. My concern is that I think most people, although perhaps not as open or willing as Senator Kerrey to talk about tomorrow, know that tomorrow is coming. I do believe we have to restructure the system, but what do we do about those people who see a short-term advantage in scare tactics or a political advantage in warning people that they may lose something that they are going to lose anyway, if we do not do anything about it?

Perhaps a sentence or two, because I am somewhat pessimistic, because the President did not join in in an opportunity to at least provide a degree of leadership in his budget message this year. I was hopeful that he would either indicate some support or direction that the commission offered him. And I am looking for ways to bring about this shared vision, notwithstanding the enormous obstacles of people who see political advantage in using us as a foil. Any reaction to how we can move together? We have a Senator who is a Democrat and a Senator who is a Republican. I wish we had some Members of the House who will share it. What do we do in getting the President onboard? He was big for reform last year on his form and function.

Senator KERREY. I would say, Mr. Chairman, that my advice may or may not be the kind of advice you would want to take, but my own thinking on it is that, for openers, we have to cool our own rhetoric and be careful in describing the problem that we do not become excessive, and that is sometimes difficult for us to do.

We do not face an immediate catastrophe. Social Security beneficiaries have not caused the problem. Sometimes in our own rhetoric—when I say our, I do not mean to include anybody in this room necessarily, but perhaps just use my own rhetoric—sometimes gets too hot and, as a consequence of that heat, I mislead and make it difficult as a result just for people to come in and say, OK, let us talk. The more we can just calmly present the facts and say, look, this is the truth, the more likely it is that we will get results.

I believe that if we can form a bipartisan group—that was the intent of the entitlement commission to begin with—in Congress that the President would be willing to take some leadership on this. I do not think the President is ducking this at all. He is saying it does not appear at the moment to be much of a critical mess. We are unquestionably going to need presidential leadership to carry the message to the people.

For example, I had staff go get a book that I should have brought with me. What the entitlement commission attempted to do both with part A and part B is to describe the future in chart form. I am going to hold it up and show it to you. But when you see it in chart form, you say, oh, my gosh, we have got to do something.

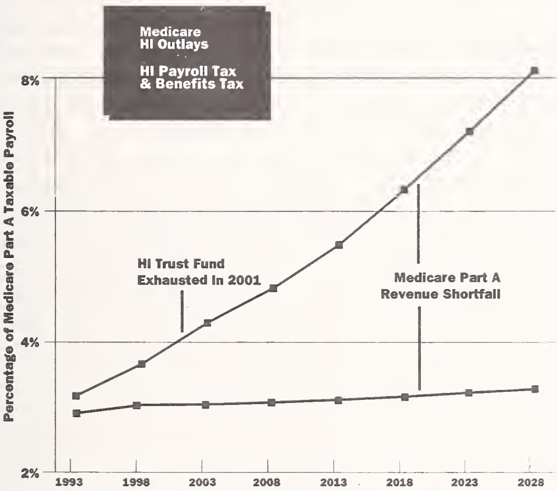
[The following was subsequently received:]

4. WE MUST ADDRESS RISING HEALTH CARE COSTS BY EMPHASIZING MARKET INCENTIVES AND PERSONAL RESPONSIBILITY.

Federal health program spending has been increasing at annual rates averaging 10 percent or more during the past five years. According to the Medicare Trustees, the Hospital Insurance (HI) Trust Fund is projected to be insolvent by the year 2001. In the long run, spending on Medicare and Medicaid will triple as a percentage of the economy by 2030. (Chart VIII)

CHART VIII: MEDICARE PART A IS PROJECTED TO BE INSOLVENT BY 2001

To cover Medicare HI outlays, the payroll tax rate would have to increase from 2.9% today to more than 8% in 2030.



When Medicare Part A was enacted, it was a self-supporting system, financed solely by payroll tax contributions. Today, Part A coverage averages about $3,100 per enrollee, while the average enrollee pays only 32 percent of the cost (26 percent for couples with only one worker). As a result, the average enrollee collects benefits equaling approximately three times the amount contributed during his or her working life.

The Kerrey-Danforth approach creates incentives in the Medicare program to control costs and introduces market forces to allow greater flexibility and a wider variety of delivery systems.

This is part A, and the blue under part A is the payroll tax, and the green here is what we are paying from the general fund. I mean that is the future. That is the fact. That is where we are going. It is not all being paid for with the payroll tax. It is increasingly being subsidized with the general fund. We have got Social Security trustees that filed a report last year that said this part A fund is going to be broke in the year 2000, and yet we are not discussing what to do about it, so just say here is the future. And our solution is apportion the cost. For all those who say, oh, my gosh, all the changes you made, it is horrible, it is terrible, I would say, look, wait a minute, all we tried to do was apportion the cost. We said the providers should take some of it, the beneficiaries should take some of it, and the general fund taxpayer could take a little. That is all we have done.

It seems to me that in the presenting of it—and part B, of course, is worse, this is part B, this red line down here is the premium and the blue line is the general fund—all we are saying is let's apportion that in some reasonable fashion. I do not know, Mr. Chairman.

I would say that the calmer we are and the less thunderous and exaggerated our rhetoric is, the more likely the response coming back, whether it is a politician such as the President, who I think does genuinely want to lead on this issue, or whether it is a group genuinely interested in the issue because they are concerned about what could happen to Social Security or Medicare, I think the more calm that we are in the presentation of the facts in the future and the more we indicate that all we are trying to do is respond to the responsibility we have to plan for that future. The more calm we can say that we are trying to plan for that future, I think the more likely it is that we will build some bipartisan coalitions.

And the more we resist those consultants that come around and say I have got a great 30-second ad that you can run here and that will make Judd Gregg look like a complete heartless fiend with blood coming out of his mouth out there lurking in the shadows ready to pounce on every person over the age of 65, the more we say to those consultants no, we are not going to do that, we are going to hold together at least on this issue, which is the most important fiscal issue that we face.

Chairman THOMAS. Thank you. I think that is an excellent reason for 6-year terms. [Laughter.]

Senator GREGG. I am a little concerned about this ad.

Senator KERREY. Our committee will not do that.

Chairman THOMAS. Thank you.

The gentleman from Nebraska.

Mr. CHRISTENSEN. I am going to remember that, Senator Kerrey, in 2 years when I need your help. That will be a good one liner I can return. I appreciate that.

In your written testimony, you talk about the CPI and how it might possibly be overstated as far as the inflationary figures. I was wondering if you could expand on this and how it affects Medicare, Medicaid and military retirement pensions and what we should do about it. I know you listed a few other statistics as far as the written testimony goes, but do you have any other thoughts on the CPI and where savings can occur?

Senator **Kerrey**. Well, the adjustments in the CPI that we have all heard an awful lot about beginning with the testimony I think that Chairman Greenspan made either before this committee or the Budget Committee, I cannot remember which one it was, but it has gotten lots of publicity and lots of amendments have been offered to things over on the Senate side. It has been a real cause celebre. That recommendation that Chairman Greenspan made is included in the Kerrey-Danforth proposal. We recommended changing, adjusting the CPI both for the calculation of benefits and for the purpose of adjusting our tax rates to avoid bracket creep.

I am going to back up again and be clear on this. This does not solve the problem. We tried to make the problem an easy thing for people to approach by developing the CD–ROM that the Chairman mentioned earlier and by saying that there are two problems that need to be solved. One is a long-term Social Security problem, out of balance, the second is entitlements that are growing beyond the growth of our economy, and so you have got to fix both problems.

In order to make it easier, we said we are going to break the problem down into 100 points. When you get 100 points, you have fixed both of them, 100 points on Social Security and 100 points on all entitlements. The CPI gets you 8 points. So the good news is it has an impact. The bad news is you have got 92 more to go.

As I said, any ideology can solve this. If a guy comes in and says I am against doing that, the next question has to be, well, what do you want to do instead, because the answers have to be I do not want to do anything, in which case they need to be exposed to somebody who is saying I do not want to solve this problem, I want to wait until it gets worse, I want to ignore all the facts, I want to ignore all the statistics, I do not care what happens in the future, all I want to do is worry about what is going to happen in the next 2, 3 or 4 years.

Senator **Gregg**. If I could address that, following up on Bob's comments. First, the CPI adjustment on the issue of accurately calculating CPI really needs to be done. Now, I was with an administration official yesterday and he was not a high ranking administration official, so hopefully he was not speaking for the administration. But he said they did not expect to see CPI recalculated or recalibrated until 1998. That obviously is not appropriate.

The CPI as it is presently structured, as Chairman Greenspan and a number of economists testified, including Mr. Reischauer, is overstating the cost of living by somewhere between 0.10 and 1.2 percent, which represents somewhere between $40 and $150 billion. The CBO's estimate is that it is overestimating it by $64 billion over a 5-year period.

That really is unfair and it is not right. When I speak to my seniors, they have no problem with this. You know, if you explain to a senior, you say if you go into Mabel's Luncheonette and you buy a $1.50 hamburger and pay Mabel $2, and you have been going there for 20 years, and Mabel by mistake gives you back 75 cents, you do not keep that quarter. You say to Mabel, "Mabel, you gave me the wrong change." Well, that is what is happening here, and the wrong change is coming from the seniors' kids, because those are the ones who are paying the taxes. So that needs to be adjusted.

There are other things that we can do in the CPI that are fair. They go to fairness issues. For example, why should retired Members of Congress have the CPI adjusted on their entire retirement income? Some retired Members of Congress get up to $100,000 or $100,000-plus. They are getting cost of living on the entire number, where a senior citizen on Social Security only gets this cost of living on the amount of their Social Security payment.

The same is true for military retirees. A rear admiral gets a retirement COLA on the entire amount of their retirement income, which might be $65,000 or $70,000. We ought to say to folks, your CPI, your COLA as a civil service retiree or as a military retiree is going to conform to what senior citizens on Social Security get for COLA, so everybody is in the same boat together. And that was a proposal that came out of the Kerrey-Danforth Commission.

So there are things that can be done on the CPI that I think go to fairness and go to accuracy and would have a compounding effect that was rather significant.

Chairman THOMAS. Any additional questions of the Senators?

[No response.]

I want to thank both of you very much. Obviously, we are not going to solve the problems in the short exchange, but I just want to tell you how reassuring it is that on a bipartisan basis you folks are talking about the same thing that we are talking about, and that is a commitment to fundamental change in the long run, because we have to.

Thank you very much.

Senator KERREY. Thank you, Mr. Chairman.

Senator GREGG. Thank you for the opportunity to testify.

Chairman THOMAS. I would ask the new Chief of Staff of the Joint Committee on Taxation, Ken Kies, and I will tell the gentleman that his entire written testimony will be made a part of the record, without objection. You may proceed for approximately 5 minutes in any way you see fit to inform us.

STATEMENT OF KENNETH J. KIES, CHIEF OF STAFF, JOINT COMMITTEE ON TAXATION; ACCOMPANIED BY MARY SCHMITT, DEPUTY CHIEF OF STAFF, AND CAROLYN SMITH, BENEFITS COUNSEL

Mr. KIES. Thank you, Mr. Chairman. I am accompanied today by Mary Schmitt, who is the Deputy Chief of Staff of the Joint Committee, and Carolyn Smith, who is Benefits Counsel.

It is my pleasure to present the testimony of the Joint Committee at this hearing concerning the Medicare part B premium. Medicare part B provides coverage for doctors' services and certain other medical services. Unlike Medicare part A, part B coverage is not automatic, but depends on the payment of a premium. All persons age 65 or older may elect in part B by payment of a monthly premium. Individuals may terminate their enrollment at any time by filing a notice with the Social Security Administration.

The part B premium currently pays about 31 percent of the actual value of the coverage in 1996 through 1998. The premium will be adjusted to be 25 percent of program costs. The approximately 70 to 75 percent part B costs that are not paid by premiums is financed through general revenues, as indicated by the two Senators that preceded me.

Over the years, there have been a number of proposals which have received bipartisan support to reduce the subsidy value of the part B program for certain beneficiaries by adjusting the part B premium.

For example, such a proposal was an option under consideration as part of the 1990 budget summit under the Bush administration. In his fiscal year 1992 budget, President Bush proposed increasing the part B premium to approximately 75 percent of program cost for beneficiaries with adjusted gross incomes greater than $125,000 for single beneficiaries and $150,000 for couples.

Last year, President Clinton included a recapture of the part B subsidy for high-income taxpayers as part of the administration's Health Security Act. During the health care reform debate, a number of proposals, including one advanced by the chairman of this subcommittee, were also debated.

If the subcommittee determines that it is appropriate to impose a part B premium that is income related, there are a number of issues that you may wish to consider, if the income related premium is assessed through the Federal tax system. Key issues for the subcommittee to decide include the income levels at which the premium would be paid and the amount of additional premium. Factors that should be taken into account in determining these amounts include the ability of taxpayers at higher income levels to pay additional premiums, revenue constraints, and the effect of increasing the premium on the decision to enroll in part B.

Whenever a tax is imposed on taxpayers with incomes above a certain level, the issue of whether the tax should be phased in should be considered. The Congress often phases in tax increases of this nature so that distortions in marginal tax rates can be minimized. Most of the proposals to impose an income related part B premium would phase in the additional premium for this reason.

The issue then presented is the income range over which the additional premium should be assessed. It may be appropriate to choose an income range that does not coincide with the phase-in range for the taxation of Social Security benefits, because virtually all Medicare-eligible taxpayers are those who are also likely to be receiving Social Security benefits.

In addition, it may be appropriate to select a phase-in range that does not result in the creation of an additional marriage penalty. In order to determine the amount of additional part B premium that is required to be paid by a taxpayer, it is necessary to determine the definition of income to be applied in determining whether the taxpayer is over the required threshold for the phase-in of the part B premium increase.

The principal goal should be to select a definition of income that accurately reflects the taxpayers' ability to pay and that is commonly calculated by the taxpayer so as to reduce the potential complexity of the premium calculation.

There are many possible definitions of income that can be employed. A commonly used definition when the phase-in technique is employed is adjusted gross income.

Whenever Congress enacts new Federal tax treatment of certain income issues, administration and enforcement must be considered. The most significant of these issues in the case of imposing an income related part B premium through the Federal income tax system is how and when all the additional premium payments should be paid and the need for new reporting or recordkeeping requirements.

It would be a relatively simple matter to collect the additional part B premium on a taxpayer's Federal income tax return. It must be determined whether the additional part B premium will be subject to the estimated tax provisions, as well.

Another issue that must be considered is whether it is necessary or appropriate to impose reporting requirements so that the IRS is capable of determining from the face of the taxpayer's return whether the taxpayer is subject to the additional part B premium.

Some people who would be subject to an additional income related part B premium may elect to decline part B coverage as a result of the additional premium. Others who are currently covered under Medicare part B may feel that enactment of an income related part B premium unfairly increases the costs of the program to them.

Under present law, persons in part B may terminate part B coverage by notifying the Social Security Administration. Thus, persons who wish to terminate coverage due to the increase in premium can do so. However, to avoid an appearance of unfairness, the subcommittee may want to consider whether it is appropriate to provide special notice of the right to terminate when the part B premium is effective.

In closing, I would like to give the subcommittee an idea of the magnitude of revenue involved if an income related part B premium were imposed. Assume an individual covered under part B were required to pay an additional premium so that the total amount paid by the individual, including a portion they already pay, equalled 75 percent of the average costs of the program. In addition, assume that this individual premium would be phased in over a $10,000 range beginning at adjusted gross income of $50,000 in the case of a single taxpayer and $100,000 in the case of a married taxpayer filing a joint return.

If this type of proposal were effective beginning in 1996, it is estimated that additional revenues of $8.1 billion would be collected over the fiscal year period 1996 through 2000. Obviously, larger or smaller amounts of revenue could be raised, depending upon where the income thresholds are set and the range over which the additional premium is phased in and the magnitude of the part B premium imposed.

That concludes my remarks, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement follows:]

TESTIMONY OF KENNETH J. KIES, CHIEF OF STAFF
JOINT COMMITTEE ON TAXATION
U.S. CONGRESS

My name is Ken Kies. I am the Chief of Staff of the Joint Committee on Taxation. It is my pleasure to present the testimony of the Joint Committee at this hearing concerning the Medicare Part B premium.

In particular, the Health Subcommittee is considering whether to reduce the subsidy value of the Supplemental Medical Insurance program under Medicare ("Part B") for certain beneficiaries by adjusting the Medicare Part B premium through the Federal income tax system. My testimony will not discuss whether adopting such a proposal is advisable (the testimony of other witnesses should address this issue), but instead will focus on the enforcement, administrative and structuring issues that could arise in implementing such a proposal. We believe that such implementation issues should be considered when proposals are being developed so that problems may be identified and addressed in a manner that imposes the least possible burden on the Internal Revenue Service ("IRS") and affected taxpayers.

First, this testimony briefly describes the Medicare Part B program under present law. Second, background information is provided on previous proposals to increase Part B premiums for higher-income beneficiaries. Third, a general description of the proposal under consideration is presented. Finally, the testimony discusses major implementation issues.

As always, the Joint Committee staff looks forward to working with the Subcommittee to develop and refine specific proposals relating to the Part B premium.

II. PRESENT LAW

The Medicare program consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program.

In general, and within certain limits, Medicare Part A pays for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Medicare Part A is financed by the Hospital Insurance Trust Fund, primarily through the payment of payroll taxes.

Most Americans age 65 or older are automatically entitled to protection under Part A of Medicare with no premium requirement based on work performed in employment subject to Social Security payroll taxes. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly Social Security or railroad retirement benefits) may obtain coverage under Part A, providing they pay the full actuarial cost of such coverage. Also eligible, after a two-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability, and disabled railroad retirement system annuitants. Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under Part A regardless of age.

In general, and within certain limits, Medicare Part B provides coverage for doctor's services and certain other medical services (such as laboratory services and outpatient hospital services), and home health services for persons not covered under Medicare Part A.

Unlike Medicare Part A, Part B coverage is not automatic, but depends on the payment of a premium. All persons age 65 or older (whether automatically entitled to benefits under Part A or not) may elect to enroll in Part B by paying the monthly premium. Persons eligible for Part A by virtue of disability or chronic kidney disease may also elect to enroll in Part B. Individuals may terminate their enrollment in Part B at any time by filing a notice with the Social Security Administration. The Part B premium is increased by 10 percent for each full year out of the program for persons who do not enroll as soon as they are eligible.

The Part B premium for any year was originally set at the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the cost-of-living adjustment (COLA) provisions of the Social Security program. Premium income, which originally financed half of the costs of Part B, declined under this formula to less than 25 percent of total program income because of the COLA limitation.

The Tax Equity and Fiscal Responsibility Act of 1982 temporarily suspended the COLA limitation for two years, 1984 and 1985. During this period, enrollee premiums were allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The suspension of the COLA provision was further extended in subsequent legislation through 1990. The Omnibus Budget Reconciliation Act of 1990 set the premium rates in law for each of the years 1991-1995, based on estimates of the amount necessary to cover 25 percent of program costs for these years. The monthly premium is $46.10 in 1995, which is projected to cover 31 percent of program costs. Because these statutory amounts were based on estimates, the premium income in any year subject to the statutory rates could be more or less than 25 percent of actual program costs. In 1996 through 1998, the premium will be adjusted to be 25 percent of program costs.

In most cases, the Part B premium is deducted automatically from Social Security or railroad retirement benefits. Eligible persons not yet receiving Social Security or railroad retirement benefits are billed quarterly.

The approximately 70-75 percent of Medicare Part B costs that are not paid by premiums is financed through general revenues.

III. BACKGROUND AND DESCRIPTION OF PROPOSAL

Over the years, there have been a number of proposals, which have received bipartisan support, to reduce the subsidy value of the Medicare Part B program for certain beneficiaries by adjusting the Part B premium.

For example, such a proposal was an option under consideration as part of the 1990 Budget Summit between the Bush Administration and Congressional leaders. In his fiscal year 1992 budget, President Bush proposed increasing the Part B premium to equal approximately 75 percent of program costs for beneficiaries with adjusted gross incomes greater than $125,000 for single beneficiaries and $150,000 for couples. Similar proposals have been made in subsequent budgets.

Last year, President Clinton included a "recapture" of the Part B subsidy for high-income taxpayers as part of the Administration's Health Security Act. Under that proposal, the Part B premium would have increased to approximately 75 percent of the program costs for taxpayers with modified adjusted gross income ("AGI") in excess of $105,000 in the case of single taxpayers, $130,000 in the case of a married couple with one spouse covered under Part B, and $145,000 in the case of a married couple with both spouses covered under Part B.

Other health care reform bills considered in the 103rd Congress contained similar proposals, including those sponsored by Congressman Michel (R-IL) and Senator Lott (R-MS) (H.R. 3080 and S. 1533), Congressman Cooper (D-TN) and Senator Breaux (D-LA) (H.R. 3222 and S. 1579), and Congressman Thomas (R-CA) and Senator Chafee (R-RI) (H.R. 3704 and S. 1770). A similar proposal was not contained in the Health Security Act as adopted by the Committee on Ways and Means, but was included in the Health Security Act as adopted by the Senate Finance Committee.

Under all these proposals, additional Part B premiums would have been collected from the affected taxpayers through the Federal income tax system.

In the 103rd Congress, H.R. 3704 was introduced by Chairman Thomas. As I have previously mentioned, this health reform bill also contained a provision to income relate the Medicare Part B premium. Under this provision, taxpayers with modified AGI in excess of $100,000 in the case of a single taxpayer and $125,000 in the case of a married taxpayer filing a joint return would have been required to pay Medicare Part B premiums equal to 75 percent of the average costs of the program for each month of the year that a Medicare Part B premium was paid. The additional premium in excess of the premium collected under present law would have been phased in between $90,000 and $100,000 of modified AGI for single taxpayers and $115,000 and $125,000 of modified AGI in the case of married taxpayers filing a joint return. Modified AGI for purposes of this provision would have been the same as the definition of modified AGI for social security benefit taxation.

I understand that the Subcommittee is considering ideas similar to those considered in the above referenced bills. Although there is no specific proposal under consideration, the general proposal being considered by the Subcommittee is that taxpayers with incomes above certain levels would be required to pay additional Part B premiums. The total premium increase would be phased in over some income levels that would be specified. In the case of married couples, whether an additional premium is owed would be determined for each spouse based on whether he or she is enrolled in Medicare Part B, using the combined income of the couple. The premium generally would be collected the same way that Federal income taxes are collected. Any additional premiums would be included as an additional amount owed on the individual's tax return for the year.

IV. ISSUES INVOLVED IN IMPOSING AN INCOME-RELATED MEDICARE PART B PREMIUM THROUGH THE FEDERAL TAX SYSTEM

If the Subcommittee determines that it is appropriate to impose a Medicare Part B premium that is income related, there are a number of issues that you may wish to consider if the income-related premium is assessed through the Federal tax system. Key issues for the Subcommittee to decide include the income levels at which the increased premium would be paid and the amount of the additional premium (i.e., whether the total Part B premium owed would be 100 percent of the program costs or a lesser amount). Factors that should be taken into account in determining these amounts include the ability of taxpayers at higher income levels to pay additional premiums, revenue constraints (if any), and the effect of increasing the premium on the decision to enroll in Medicare Part B.

My testimony focuses on issues that arise regardless of the decisions as to particular income levels or premium levels. In adopting a particular proposal, I would encourage you to consider implementing it in a manner that is easiest for both taxpayers and the IRS to administer.

Phasing in an income-related Part B premium

Whenever a tax is imposed on taxpayers with income above a certain level, the issue of whether the tax should be phased in must be considered. If a higher rate of tax is assessed on income above a certain level, a taxpayer's marginal tax rate increases as income rises. If a specified amount of additional tax is imposed for taxpayers with income above certain levels, the marginal rate for the first dollar of income above the threshold could be extraordinarily high, unless the additional tax is phased in over an adequate income range to smooth the effects of the phase in.

For example, suppose the Congress imposed a $1,000 surtax on taxpayers with income in excess of $50,000 per year. Ignoring any other taxes that a taxpayer might owe, if this tax were not phased in, a taxpayer with $50,001 of income would be required to pay additional tax of $1,000. This would result in a marginal tax rate (assuming no other taxes) on that $1 of additional income of 100,000 percent. On the other hand, a taxpayer with income of $100,000 would be subject to a marginal tax rate of 2 percent on his income in excess of $50,000.

The Congress often phases in tax increases of this nature so that these distortions in marginal tax rates can be minimized. Most of the proposals to impose an income-related Medicare Part B premium would phase in the additional premium for this reason. The issue then presented is the income range over which the additional premium should be assessed.

It may be appropriate to choose an income range over which the additional Part B premium is phased in that does not coincide with the phase-in range for the taxation of Social Security benefits. Because virtually all Medicare-eligible taxpayers are those who are also likely to be receiving Social Security benefits, the effect of imposing a Medicare Part B premium increase over the same income range as the taxation of Social Security benefits is phased in could result in what the Congress would conclude is an inappropriately high marginal tax rate for the affected taxpayers.

Under present law, taxpayers with income in excess of $25,000 in the case of a single taxpayer and $32,000 in the case of married taxpayers filing a joint return must include in income up to 50 percent of their Social Security benefits. In addition, taxpayers with income in excess of $32,000 in the case of single taxpayers and $44,000 in the case of married taxpayers filing a joint return must include in income up to 85 percent of certain of their Social Security benefits. The additional amount that must be paid phases in as income above these amounts increases relative to the amount of Social Security benefits received. The Contract with America would repeal the second level of Social Security taxation. In general, under present law, if the increased Part B premium began at incomes in excess of approximately $36,000 for single individuals and $52,000 for married taxpayers, the taxation of Social Security benefits would be fully phased in before the Part B premium had an effect. If the Contract With America provision relating to the repeal of the tax increase in social security benefits enacted in the Omnibus Budget Reconciliation Act of 1993 is enacted, then the levels at which the taxation of social security benefits is fully phased in would generally be reduced to $32,200 for single taxpayers and $46,400 for married taxpayers filing a joint return.

In addition, it may be appropriate to select the phase-in threshold and range in such a manner that the adoption of a proposal to income relate the Part B premium does not result in the creation of an additional marriage penalty. Under present law, in the case of a married couple in which both spouses have income, it is possible that the couple will pay more Federal income tax by filing a joint return than the amount of tax that would be due if each of the spouses were eligible to file as single individuals. This is the so-called marriage penalty. The Contract With America contains a provision that is designed to reduce the marriage penalty to some extent. If the Subcommittee believes that it is important to minimize the marriage penalty, then it would be necessary to set the phase-in threshold for a married couple for purposes of the additional Part B premium at two times the threshold for single individuals. In addition, because the amount of the additional Part B premium owed by a couple is dependent upon whether one or both of the spouses is covered under Medicare Part B, it may be appropriate to phase in the additional premium over the same range as an individual taxpayer in the case of a married couple with only one spouse covered under Medicare Part B and over two times the phase-in range of an individual taxpayer if both spouses are covered under Medicare Part B.

You may also wish to consider indexing the income levels over which the increased premium is phased in. If the income levels are not indexed, then, over time, the real income level at which the premium is phased in will decline and people with lower real incomes will be subject to the additional premium. This effect will be exacerbated if the Part B premium increases over time.

Definition of income

In order to determine the amount of additional Part B premium that is required to be paid by a taxpayer, it is necessary to determine the definition of income to be applied in determining whether the taxpayer is over the required threshold for the phase in of the Part B premium increase. The principal goal should be to select a definition of income that accurately reflects the taxpayer's ability to pay and that is commonly calculated by taxpayers so as to reduce the potential complexity of the premium calculation.

There are many possible definitions of income that could be employed. A commonly used definition when the phase-in technique is employed is adjusted gross income (AGI). Often, AGI is the starting point in the definition of income and then additional adjustments are made to reflect more accurately a taxpayer's ability to pay.

One definition of income used by almost all taxpayers who would be subject to the additional Part B premium is the definition used for purposes of the taxation of certain Social Security benefits. This definition begins with AGI, but is adjusted to include tax-exempt interest income and to disregard the exclusion from income for interest on certain educational savings bonds and certain foreign tax credits and exclusions. Use of this definition would have the advantage not only of using a definition already employed by the class of taxpayers affected by the Part B premium increase, but also of ensuring that the marginal tax rate concerns addressed above could be mitigated.

Administrative issues

Whenever the Congress enacts new Federal tax treatment of certain income, issues as to administration and enforcement must be considered. The most significant of these issues in the case of imposing an income-related Part B premium through the Federal income tax system are (1) how and when will the additional premium be paid and (2) the need for new reporting or recordkeeping requirements.

It would be a relatively simple matter to collect the additional Part B premium on a taxpayer's Federal income tax return or Form 1040 for each year. It must be determined whether the additional Part B premium will be subject to the estimated tax provisions or whether it will merely be collected as a separate tax on the Form 1040. If it is collected through the estimated tax system, then the additional premiums will be collected more closely to the time that the Part B coverage is provided. On the other hand, a taxpayer will not know with certainty whether his or her income for the year will be sufficiently high so that the additional Part B premium will, in fact, be owed and, if so, the amount of the additional premium. Thus, it may be a simpler calculation for taxpayers if the additional Part B premium is collected only at the end of the taxable year and is not subject to estimated tax payments during the year. To resolve this issue, the Subcommittee will have to determine whether simplicity of the calculation for taxpayers outweighs the Federal government's interest in collecting the additional Part B premium close to the time that the coverage to which the premium relates is provided.

In some cases, a taxpayer's AGI may be redetermined by the IRS after the tax return is filed. Such a redetermination could affect the amount of additional Part B premium that is owed, and could mean that the taxpayer is entitled to a refund or owes an additional amount. If the Part B premium is treated the same as Federal income taxes, then the IRS will automatically recalculate the Part B premium if AGI is redetermined and will make appropriate adjustments to the taxpayer's total tax liability.

Another issue that must be considered is whether it is necessary or appropriate to impose reporting requirements so that the IRS is capable of determining, from the face of a taxpayer's Form 1040, whether the taxpayer is subject to the additional Part B premium. For example, the Subcommittee might consider whether it is appropriate to require that a statement be provided to a Medicare-covered individual for each year indicating the months of Medicare Part B coverage for the year. This statement could then be attached to the taxpayer's Form 1040 for the year. However, in virtually all cases, a taxpayer who is subject to the additional Part B premium would also be claiming the additional personal exemption for the elderly. In such a case, the IRS would generally know that a taxpayer with sufficiently high income who is also claiming an additional personal exemption for the elderly is likely to be required to pay the additional Part B premium. In some cases, a taxpayer who claims an additional exemption for the elderly will have been covered by Medicare Part B for only part of a year, but it should be a relatively minor problem to resolve discrepancies in such cases.

Some taxpayers who are under age 65 are also Medicare eligible (e.g., certain disabled individuals or individuals with end-stage renal disease) and may have sufficiently high income that they would be required to pay the additional Part B premium. The Subcommittee should consider whether it is appropriate to adopt a specific reporting requirement to ensure that high-income taxpayers who are under age 65 and covered under Medicare are paying the additional Part B premium. However, this may be such a small class of taxpayers that it may not be worth the administrative costs of imposing such a reporting requirement.

Fairness

Some people who would be subject to an additional income-related Part B premium may elect to decline Part B coverage as a result of the additional premium. Others who are currently covered under Medicare Part B may feel that enactment of an income-related Part B premium unfairly increases the cost of the program to them. They may argue that they would not have elected Part B coverage in the first place if they had know that they would be subject to a significant premium increase. Under present law, persons in Part B may terminate Part B coverage by notifying the Social Security Administration. Thus, persons who wish to terminate coverage due to the increased premium can do so. However, to avoid an appearance of unfairness, the Subcommittee may want to consider whether it is appropriate to provide special notice of the right to terminate coverage when the Part B premium is effective, and the consequences if the person would later like to again be covered (i.e., the premium increase). The costs of providing such a notice should be weighed against the benefits to Part B recipients.

V. CONCLUSION

In closing, I would like to give the Subcommittee an idea of the magnitude of the revenue involved if an income-related Medicare Part B premium were imposed. Assume an individual covered under Medicare Part B were required to pay an additional premium so that the total amount paid by the individual equaled 75 percent of the average costs of the program. In addition, assume that this additional premium would be phased in over a $10,000 range beginning at AGI of $50,000 in the case of a single taxpayer and $100,000 in the case of a married taxpayer filing a joint return. If this type of proposal were effective beginning in 1996, it is estimated that additional revenues of $8.1 billion would be collected over the fiscal year 1996-2000 period. Obviously, larger or smaller amounts of revenue could be raised depending upon where the income thresholds are set, the range over which the additional premium is phased in, and the magnitude of the Part B premium imposed.

Chairman THOMAS. Thank you very much, Mr. Kies.

Mr. Crane, do you have an interest in inquiring?

Mr. CRANE. Just one.

Ken, do you believe that using the Federal tax system to impose an income related Medicare part B premium is actually workable?

Mr. KIES. Mr. Crane, it would require relatively little modification to the actual tax return to be able to collect it, so it imposes relatively small additional complexity.

Mr. CRANE. That is all. Thank you.

Chairman THOMAS. Mr. McCrery.

Mr. MCCRERY. Ken, would you go over that revenue estimate again?

Mr. KIES. Under the particular proposal that I——

Mr. MCCRERY. I got the $50,000 and $100,000. I got all the details. I just missed the number.

Mr. KIES. The number is $8.1 billion over a 5-year period.

Mr. MCCRERY. $8.1 billion, that is it.

Mr. KIES. Now, you can change it. For example, if you were to impose it at $50,000 for a single and $75,000 for a married couple, it raises $12.4 billion. So where you put the threshold amounts obviously has a lot to do with it. And keep in mind under that proposal we would be charging 75 percent of the total cost. So if you took it up to 100 percent, you would probably see the revenue increase by 30 or 40 percent.

Mr. MCCRERY. Have you given some thought as to how we should define income?

Mr. KIES. Clearly, the simplest approach would be adjusted gross income. However, in an attempt to more closely approximate ability to pay, you may want to add, for example, tax-exempt interest which would not normally be includable in adjusted gross income. Clearly, I think the simple starting point would be adjusted gross income, since it is already determined on the return and making it easy for people to determine what point they are at relative to the thresholds I think is fairly important for the ability to administer.

Mr. MCCRERY. If we are really looking to get those who are able to pay something closer to the true value of what they are getting, then we should consider something other than the AGI or something in addition to the AGI.

Mr. KIES. If you were trying to get closer to ability to pay, you would want to pick up other forms of income that are significant. Tax-exempt income could be a significant item. There does not immediately come to mind anything else that probably fits into that category that is probably as prevalent among those in the over age 65 category.

Mr. MCCRERY. And how do we go about getting that information?

Mr. KIES. We have data relative to distribution of tax-exempt income. Currently, I think you have to check a box on your return if you do have tax-exempt income, because it can enter into minimum tax calculations and things like that. So that would not be a significant increment and complexity, if that were the definition that the subcommittee wanted to choose.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. KIES. The one other element is the fact that Social Security income is not currently all included, because currently you are only taxed certain amounts over certain thresholds, so that is probably the one other significant source of income besides tax-exempt income.

Chairman THOMAS. I thank the gentleman.

Obviously, in your capacity we are going to be asking you to slice this particular apple in a number of different ways. I think the record needs to show that, although obviously the Joint Tax Committee and the Ways and Means Committee ultimately looks at the question of revenue and how these changes might generate *x* number of dollars, what we are also doing is talking about equity and fairness in terms of a policy, since in focusing on part B we want to underscore again that this is money that comes, except for the small portion from the beneficiaries, out of the general fund and that it is a gift to individuals, with no relationship to their wealth.

An idea that I want to begin exploring with you is the idea that Senator Gregg mentioned, the concept of a Medicheck or an ability to allow someone to take the actuarial value of the Medicare program and spend it in the private sector for health goods and services, and that perhaps the amount of the Medicheck might be structured in a way in which the more wealthy individual got a smaller check. As you understand the concept, would there be any more complexity in trying to work out a structure like that than the one that you just discussed, which is the question of how much you have on your AGI and adjust it in terms of how much you would get on the 80/20 split?

Mr. KIES. I guess my initial thought, Mr. Thomas, is that most of the complexity would be associated with the fact it would be something new and different. If we were to use adjusted gross income as the means of determining how much of a Medicheck each individual would be entitled to, then the actual mechanics would not be significantly dissimilar to what we are talking about here.

Chairman THOMAS. So from a mechanical point of view, in a general sense, we do not really have a problem. We worked in this area enough that we could solve it. It is just the policy that has to be determined?

Mr. KIES. I think that is correct, substantially a health care issue policy, as opposed to how you do it through the tax system.

Chairman THOMAS. Thank you very much.

Any further questions?

[No response.]

I do think for the record we should indicate that the U.S. Treasury was asked to testify at this hearing and they declined and submitted no written testimony.

Could we then ask for the next panel, which may begin to bridge the gap between tax policy and health care policy. Coming forward on this panel would be Stuart Butler, who is vice president of the Heritage Foundation, and Gail Wilensky, who is a senior fellow at Project HOPE, and someone who has participated in the previous administrations in a number of leadership capacities, among them HCFA and others in the Bush administration.

Thank you very much for your willingness to testify in front of the subcommittee. I will say that any written statement that you have will be made a part of the record, without objection.

Stuart, if you want to begin, you can inform us in any fashion you see fit that would get the message across.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT, THE HERITAGE FOUNDATION

Mr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify today on the future of the Medicare part B program.

I believe that Congress needs to approach reform of the program this year with two objectives firmly in mind. First, entitlements like part B need to be reviewed for ways to reduce the net outlays of the Federal Government as part of a general commitment to reducing the Federal deficit. Second, Medicare, like all other programs of the Federal Government, needs to be subjected to a bottom-up review to explore better ways of achieving its objectives, as the two Senators both said earlier. The American people sent a strong message last November that they wanted such a review of all government programs.

The options for changes in part B, as I suggest in my written testimony, are intended to meet the first objective, but are also compatible with the second. To achieve broad-based structural changes in Medicare, I believe Congress should begin to institute changes that will move Medicare away from the current highly regulated system toward a system that provides eligible Americans with a fixed contribution toward the health plan of each retiree's choice. In that way, senior citizens with their doctor's advice could pick the range of benefits and type of plan that best meets their needs. And they would also have the incentive to choose the plan offering them the best value for the money.

In short, Mr. Chairman, retirees and the disabled would be given the same freedom as Members of Congress to choose the type of plan that is right for them. I think as Senator Gregg emphasized, the FEHBP is a very different kind of program in terms of the incentives that apply to Federal workers and to Members of Congress. It is instructive that its rate of premium increase has been so low for many years, and I think it is a clear indication that a different dynamic occurs in that program compared with Medicare. So I would strongly urge Congress to combine changes in part B premiums with initial steps toward a reformed system of that kind.

In my written testimony, I lay out the arguments for raising the part B premium in concert with the general reform of Medicare. It is important to remember some things about part B. As you pointed out yourself, Mr. Chairman, unlike the hospital insurance segment of Medicare, part B is a voluntary program. It is not a social insurance program. In reality, it is a below-cost commercial service offered by the Federal Government. The beneficiaries' contribution is a flat amount unrelated to income, and the program is heavily subsidized by the general taxpayer, even for very affluent retirees.

When the part B program was launched, the subsidy rate was 50 percent. It is now closer to 75 percent of outlays. Thus, part B today allows affluent elderly Americans to choose a health insurance plan offered by the Federal Government in which most of the tab is picked up by the taxpayer. It is little wonder that 97 percent of the eligible population sign up for part B. It is hard to justify the generous subsidy, however, at least for those who do not need it, when so many cuts are being considered in so many other programs.

Part B costs also are growing at an alarming rate. The trustees' report in 1994 expressed great concern about the growth in spending. As the Kerrey Commission pointed out, the cost to taxpayers will increase sharply in the future. One way Congress can begin to rein in this sharp growth in taxpayer costs is by requiring those who can afford it to shoulder a greater share of the cost.

The heavy subsidy of part B also discourages the elderly from choosing plans that would better provide them with better health care at a lower real cost. Because part B charges the elderly only 25 cents on the dollar, far more innovative and efficient plans in the private sector cannot compete on price. Raising the part B premium would create a more level playingfield and encourage seniors to pick more efficient plans.

Even better, of course, would be for Congress to convert the part B subsidy into a fixed payment toward the plan of the eligible person's choice, one free of the rigidities of the current part B rules. That would allow elderly Americans to choose from a wider array of different types of plans and, thus, stimulate innovation and better services for the elderly.

Raising part B premiums, Mr. Chairman, is not a tax increase. You will not find officials of the Heritage Foundation coming to Congress to advocate tax increases. What we do advocate is that when the Federal Government offers an essentially commercial service to corporations or individuals, generally it should charge the full cost. That goes for airport landing fees, as well as for health insurance. If a particular group of Americans truly deserve to be subsidized, then they should be subsidized directly, not through a price break available to everyone else.

Raising part B premiums means cutting the subsidy that should not be available to many Americans. The issue is how to reduce that subsidy in the fairest way. In my testimony, Mr. Chairman, I suggest three options available to Congress, but several variants are possible.

To summarize them, Congress could look at raising the part B premium to the full cost of the program. That would save a great deal of money, but it would impose enormous costs on low-income Americans. Raising the premium back to the percentage that was envisioned when Medicare was launched, at 50 percent, obviously would save less money, but would still retain a large subsidy to people who do not need it.

That is why I think that the third option, the compromise that others already mentioned, is the one to explore. That would be to means test premiums for upper-income beneficiaries. This option accepts that subsidizing needy Americans is a function of Medicare part B, but would limit that subsidy to those who need it most. A wide range of formulas could be used, but essentially Congress would continue the current level of subsidy up to a certain threshold and then phase out the subsidy—that is, raise the premium in increments as income rises until the premium covers the full cost of coverage.

Mr. Chairman, I must emphasize again, in conclusion, that premium changes should be instituted in tandem with initial steps toward a general restructuring of the Medicare program. It is necessary to curb the costs of the Medicare program and the costs of other entitlements. The aim of the structural changes should be a Medicare system in which retirees receive a contribution toward the cost of coverage when adjusted according to income which they may use to enroll in the plan of their choice.

Such a system would have to be introduced gradually and would require certain changes in insurance rules for private insurance plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control, while assuring the widest choice and value for money for retirees, budget savings must be accompanied with the first steps toward structural reform.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF STUART M. BUTLER
THE HERITAGE FOUNDATION

Mr. Chairman, my name is Stuart Butler. I am a Vice President at The Heritage Foundation. I appreciate the opportunity to address the subcommittee on the issue of Medicare Part B. I emphasize that the views I express are my own, and should not be construed as representing any official position of The Heritage Foundation.

The American people sent the powerful message last November that they want Congress to undertake a radical overhaul of government. They want Congress to review the activities of the federal government to determine how to move functions closer to the people. They want Congress to curb the growth of government and its intrusion into their lives. And they want Congress to look at how to reform those programs within the domain of the federal government so that they can better achieve their stated purposes.

Congress has an unprecedented opportunity to undertake such a fundamental reform of the Medicare program. It must do so in the context of the immediate need to take steps to balance the books of the federal government and to rein in the huge growth in federal spending over the last several years, which has pushed the country into debt while raising the burden of taxes on Americans. More specifically, Congress must consider Medicare reform in the context of a general reform of entitlement spending. None of the entitlement programs can be considered "off the table" as Congress grapples with the deficit -- especially programs that provide large subsidies to one generation by passing the tab to the next.

The Medicare system thus should come under careful review, to see if sensible savings can be achieved while reforms are undertaken. As I will point out in this testimony, among the many possible reforms to achieve a reduction in the growth of net outlays of Medicare, Congress should consider is an increase in the heavily-subsidized Medicare Part B premium. As I will explain, this can be justified whether or not the objective of the reform is to reduce net outlays.

Still, any changes in the Medicare Part B premium should be taken in tandem with steps towards structural reform of the entire Medicare program. That structural reform should move Medicare away from the current highly-regulated system, characterized by complex price and volume controls and Washington-specified services, towards a system which seeks to protect the health of eligible Americans as economically as possible. In this latter, reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution towards the cost of the chosen plan.

With the government making a fixed contribution for each retiree, Medicare beneficiaries not only would have the freedom to choose the benefits and type of plan they preferred (such as fee-for-service or managed care), but they would also have the incentive to seek out the best value for money among plans. This reform would give retirees in Part B choices and incentives very similar to those applying to Members of Congress under the Federal Employee Health Benefits Program. It is no coincidence that the FEHBP has managed to keep increases in enrollee costs well below those of Medicare and, more significantly, those of corporate health plans, while maintaining a high level of satisfaction.

The possible changes in the Part B premium I will review are compatible with this structural reform.

The Case for Raising Part B Premiums

The Medicare Supplementary Medical Insurance (SMI) program, known as Part B, pays for physician services, outpatient hospital services, and other medical expenses for Americans aged 65 and over and for the long-term disabled. Unlike the hospital portion of Medicare (HI), enrollment in Part B is voluntary. And unlike the HI program, Part B services are paid for through a system of premiums (supplemented with general revenues) rather than with the payroll taxes. According to the most recent report of the Board of Trustees, SMI disbursements in 1993 were $57.8 billion ($54.0 in benefits). The program received $41.5 billion in general revenue contributions in 1993 (71.9 percent of income).[1]

This subsidized, voluntary program is very popular. At the time of its enactment on July 1, 1966, 17.7 million aged persons enrolled in Medicare Part B. This population has steadily increased over time. In 1990, 32.6 million aged persons were enrolled in Medicare Part B. In 1995, 35.7 million persons are enrolled in Part B, or 97 percent of the total Medicare population. In 1990, 3.2 million enrollees were covered under both the Medicare and Medicaid programs (The state paid for premiums and required cost sharing expenses).

There are several reasons for making changes in the Part B program, and in particular for requiring some beneficiaries to shoulder a higher proportion of program costs. Among them:

1. Part B is a heavily subsidized entitlement without regard to income or any past contributions

Unlike the HI program (Part A), the benefits available from Part B are not even in theory based on contributions made by recipients during their working years. Instead it is a government-sponsored health insurance program that is heavily subsidized by taxpayers (including many elderly Americans who have chosen not to enroll).

The subsidy is roughly three dollars for every dollar of premium paid. More precisely, beneficiaries in 1993 contributed just 24.6 percent of program income.[2]

When Part B was established, it was Congress' intention to provide a subsidy, but at a much lower rate than today. Until 1973, SMI premiums were set by law to finance one half the benefit and administrative costs of the program plus a small contingency amount to go into a separate trust fund. However, in 1972, Congress amended the Social Security Act and drastically altered that arrangement. Beginning in July 1973, SMI premiums could be increased only if monthly Social Security cash benefits were increased. Premiums are permitted to rise no more than the percentage increase in cash benefits. Since the 1972 amendments, the proportion of Part B income contributed by enrollees has declined, and so the degree of subsidy has increased. Enrollees in 1995 pay a premium of just $46.10 for insurance that covers 80 percent of allowable charges with a deductible of only $100. Had the original deductible been allowed to rise in line with outlays, it would be over $1,000 today. With such inexpensive and generous coverage, subsidized by the taxpayer, it is little wonder that almost all eligible Americans decide to enroll in Part B.

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[1] Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1994 Annual Report of The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington D.C.: US Government Printing Office, April 1994), p.1

[2]

When working Americans are facing up to the need to tighten their belts and accept reductions in federal programs, it is hard to see why, at the very least, more affluent retirees should not contribute a larger share of the cost of Part B. While Medicare Part B requires the payment of premiums, it is actually an income transfer program, taking away income from one segment of the population and redirecting it to another, without regard to the latter's income.[3]

2. Part B costs are growing at an alarming rate

In the 1994 Trustees' Report to the Congress, the financial outlook for Medicare Part B is not encouraging. While the Trustees believe the SMI program is currently actuarially sound, they "[n]ote with great concern the past and projected rapid growth in the cost of the program...Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last five years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program."[4] While the Trustees do not make any long range projections like they do in the HI (Part A) program, they point out that the SMI program will be affected by many of the same factors that are projected to increase Part A's costs (medical inflation, a rapidly aging society, etc.)

Part B outlays are growing at such a rapid rate that they are consuming an ever-larger share of the gross domestic product (GDP), as are HI expenditures. In 1993, Part B spending constituted 0.88 percent of GDP. This year the proportion is projected to be 0.99 percent, and in just 10 year's time the proportion is projected to be 1.17 percent.[5]

Such an alarming rate of increase in a program, particularly a voluntary enrollment program, demands congressional action to curb the growth of future outlays, by benefit reductions and/or by requiring at least some beneficiaries to shoulder a greater share of costs.

3. The generosity of Part B subsidies is a barrier to finding more economical and efficient ways of providing health care services to the elderly

Since enrollees pay only 25 percent of the costs of Medicare Part B, insurance alternatives to the program generally are very unattractive even if they are actually much more efficient in delivering services -- unless the proportion of the premium paid by the private sector enrollee is close to 25 percent. Some corporate retiree plans require low cost sharing from beneficiaries, and so are competitive with Part B. But if, say, a retiree had to pay the full cost of equivalent insurance coverage, Part B could be almost three times as costly in delivering services (including overhead) and it would still be more attractive to the retiree. There are good reasons to believe that because of this wide price differential, made possible by the heavy subsidy, Part B is under less pressure to realize true efficiencies. Its payment schedule is a highly complex price control system, for instance, and is very inflexible, and only nine percent of enrollees are in managed care. In the competitive private sector, by contrast, there is continuous adjustment of pricing and benefit levels as plans seek greater efficiency, and there has been a quite dramatic shift in recent years to managed care.

Reducing the subsidy level in Part B would encourage many retirees to compare the costs and benefits of private alternatives with those of the Part B program. The further the subsidy were reduced, and hence the more level the playing field, the greater would be the inducement to pick more efficient private plans. That would lead to a reduction in the outlays of the program.

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[3] David Koitz, *Medicare Taxes, Premiums, and Government Contributions for 1995*, CRS Report for Congress, p. 2, December 20, 1994.

[4] *1994 Annual Report*, p. 3.

[5] Guy King, "Health Care Reform and the Medicare Program," *Health Affairs*, volume 13, no. 5, Winter 1994, p.41. Projections based on Trustees Report.

Whether or not the subsidy level is reduced, the desire to introduce greater incentives for efficiency has led many analysts to favor reforms that would reconstitute Medicare Part B (and Part A) into the equivalent of a voucher program, to give the elderly the opportunity and incentive to choose plans and benefits that are very different from Part B. This reform would not, in itself, change the government's contribution to retirees, but it would give them far more freedom of choice and a strong incentive to seek the best value for money among private-sector plans competing on an equal footing with the Part B program.

Options for Raising Part B Premiums

Not a Tax Increase. If this subcommittee gives serious consideration to reducing the level of subsidy by raising the Part B premium, members no doubt will be accused by some critics as favoring a tax increase.

An increase in the Part B premium is *not* a tax increase.

Members of this subcommittee can feel very confident that as a senior official of The Heritage Foundation, I would not come before you and advocate a tax increase. On the other hand, while opposing tax increases, we at Heritage have consistently argued that individuals or corporations receiving an explicit service from government -- especially one which could also be provided by the private sector -- should pay the full cost of that service unless there is some pressing reason for a subsidy (such as poverty). And such as subsidy should be explicit, rather than hidden in the price of the service. This is why scholars from The Heritage Foundation have testified before various committees and published studies advocating full-cost user fees for commercial services available from the federal government.

Part B is a "commercial" service provided by the federal government. If there is to be a subsidy for enrollees in the program, it should be restricted to those whom Congress has determined cannot reasonable afford an acceptable level of physician services and other services available under Part B. There is a strong case for ending the subsidy available to other Americans.

While a case can be made for greater cost sharing in Part A, the case is much stronger for Part B. Americans contribute to their Part A benefits throughout their working life. Those contributions are mandatory and are income related. Thus there is reasonable argument against mean-testing Part A or reducing benefits if they fall below the equivalent value of payroll contributions. No such argument applies to Part B. Part B is voluntary -- retirees and the long-term disabled examine the cost of coverage under the subsidized Part B program and under private alternatives and choose whether or not to enroll.

Under current law, according to the Congressional Budget Office, the federal government is projected to spend $485.9 billion over the next five years in Part B payments (of which premium payments cover just 25 percent).[6]

Outlays (in billions of dollars)

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[6] Congressional Budget Office, "CBO December 1994 Baseline, Outlays by fiscal year, in billions of dollars," January 9, 1995.

1996	1997	1998	1999	2000
75.3	85.3	96.1	108.0	121.2

There are several options available for raising Part B premiums.

Option 1) Raise the beneficiary premium to 100 percent of costs.

While obviously the most difficult option politically, this change could achieve net savings to the program of as much as $364 billion over five years, depending on the assumptions made.[7] Even if this sharp increase had applied in 1995, beneficiaries still would pay just $184.40 per month for good coverage.

But needless to say, this change would be a great hardship for many lower-income Americans. It would also be a new burden to states, unless states chose to maintain their current level of financial support for individuals also on Medicaid -- in which case these low-income Americans would face relatively large premium costs.

Option 2) Raise the premium contribution level to 50 percent of costs.

Congress originally set the premium for Part B at 50 percent of costs, and so this option would merely reinstate that premium percentage. This would still retain a heavy subsidy to enrollees, regardless of income. Had this change been in effect in 1995, premiums would be $92.20 per month. The net savings to the government from this change would be as much as $121.5 billion over five years.

While lower-income enrollees would not be affected by this change as much as under option 1, many would still face hardship -- while upper-income enrollees would continue to be heavily subsidized.

Option 3) Means-test premiums for upper-income beneficiaries.

A compromise change would be to reduce the subsidy as income rises. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced.

A general concern about any means-testing system is that it has the equivalent effect of raising marginal tax rates for individuals enrolled in the program, since premiums rise with income. Still, this effect could be kept quite small. Consider the following change:

> Gradually reduce the Medicare Part B premium subsidy for "high retirement income" beneficiaries. The threshold begins at $65,000 adjusted gross income for individuals and $85,000 for couples. The subsidy is phased out in increments of 3 per cent per $1,000 of income above the threshold. The full premium would be paid by individuals above $98,000 AGI and couples above $118,000 in AGI.

The increase in equivalent effective marginal tax rate in this case would be approximately 5 percentage points.

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[7] A change of this magnitude would have large behavioral effects which are beyond the scope of this analysis. Clearly one effect would be that the number of persons enrolled in Part B would decline, as individuals comparing premium costs chose more competitive private plans. That would reduce outlays and the net savings to the deficit.

While these reductions in the subsidies in Part B would yield savings to taxpayers, I must emphasize again, in conclusion, that such changes should be instituted in tandem with initial steps towards a restructuring of the Medicare program. The aim of the structural changes should be a Medicare system in which retirees receive a contribution towards the cost of coverage (perhaps inversely related to income) which they may use to enroll in a plan of their choice. Such a system would have to be introduced gradually, and would require certain changes in insurance rules for plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control, while assuring the widest choice and value-for-money for retirees, structural reform is essential.

Chairman THOMAS. Thank you very much, Dr. Butler.

Ms. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE

Ms. WILENSKY. Thank you.

Mr. Chairman and members of the subcommittee, I thank you for inviting me to speak before you today. I know that you are in the middle of a series of hearings on Medicare and commend you for the review that you are undertaking. It is important to consider Medicare in its entirety, although I recognize that today's hearing focuses on part B. It is important that whatever changes are made to the Medicare program are made with long-term objectives in mind.

Medicare is in serious need of reform. Part A, funded by the trust fund, as you have heard is running out of money. According to the intermediate assumptions, the latest trustees' report projects that the HI Trust Fund will be bankrupt in the year 2001. I know you have heard that before, but it is important that we keep stating this fact.

While part A does not have the immediate impact on the deficit of part B, the need for change is clear and unmistakable. Part B, which is financed three-quarters by the general fund and one quarter by premium payments from the elderly, poses a different set of problems. It is not a trust fund which is being drained of resources, but, rather, the Federal budget that is being adversely affected.

At a time when spending in the private sector has slowed dramatically, the increases in spending for Medicare continues in double digits. Between 1983 and 1991, Medicare spending grew more slowly than spending in the private sector. But since 1991, Medicare has grown substantially faster, 6.5-percent versus 4.7-percent growth in real spending adjusted for inflation per capita.

The differential appears to be even more dramatic in 1993–94, where spending in the private sector increased at a rate of 2.5 percent, while spending for Medicare increased at a rate exceeding 10 percent. According to CBO baseline estimates, part B growth for fiscal year 1995 is 10.9 percent, with growth rates between 12 and 13 percent per year for the remainder of the decade.

Even growth rates in spending for the physician component, which in this fiscal year was projected to grow less than 6 percent, are expected to grow between 9 and 12 percent per year throughout the rest of the decade. The growth rates for durable medical equipment, laboratories, outpatient hospital spending, and other part B costs are projected to grow even more rapidly.

But we should not be surprised at this outcome. There are few incentives for the elderly to seek cost-effective providers or for their physicians or medical suppliers to limit the spending on them. It is particularly a problem for hospital outpatient spending and clinical lab procedures, but it is also a problem in your efforts to moderate physician spending.

An individual physician's behavior has little bearing on the changes in fees to that individual physician, as a result of expenditure goals being met or not met. And this combined with the cost-increasing incentives inherent in a la carte fee-for-service medicine means that there are few incentives for physicians to practice cost-efficient and prudent medicine, and no rewards for those that do.

Effective reforms will need to change the basic incentive structure associated with Medicare. There is no incentive for the elderly to see cost-effective physicians or hospitals or to use lower cost durable medical equipment, laboratories or outpatient hospitals. Similarly, hospitals are encouraged to increase the use of outpatient admissions and procedures and physicians are rewarded for doing more, when doing less might be as good or better.

Ultimately we need to reward the elderly for choosing more cost-effective plans. We need to provide incentives for physicians and hospitals to order and prescribe the cost-effective medicine that is available and to be willing to share the savings which an aggressive reorganization of health care can produce.

I believe that a better use of a redesigned adjusted average per capita payment, the AAPCC payment which is currently used for capitated plans, could become the basis of a voucher or that some other vehicle, like Mr. Thomas' Medicheck, which would encourage the cost-effective choices could be put in place. It would require redesigning the determinants of the AAPCC, making it more stable, taking better account of risk selection, and also opening up more choices toward which the payment can be made.

I have a number of specific suggestions for making these changes, such as having Medicare Select available everywhere, allowing point-of-service plans, having partial capitation and several other specific reforms that I hope you will consider.

In the short term, however, it is possible to make changes that will move the Medicare system toward a better direction. Targeting the subsidy associated with part B so that it is more focused on low-income elderly, and so that it encourages more cost-effective choices of plans would begin to move us in a better direction than where we are now.

There are several ways to do this. One is to keep the part B structure as it is for the poor and middle-income elderly and gradually reduce the subsidy from its current level of 75 percent to a 25-percent level for upper-income elderly. These reduced subsidies could begin for individuals with incomes of $50,000, $75,000 or $100,000, depending on your perception as to where reduced subsidy should begin, and also on the revenue needs of the Congress. Proposals of this nature were included in the previous two sessions of Congress.

A second strategy would be to increase the part B deductible to $1,000 from its current level of $100. This would actually represent the $50 deductible originally introduced in 1965 indexed for medical inflation. As long as you kept the qualified Medicare beneficiary, the so-called QMB program, in place, and regular Medicaid payments for the poor elderly, there would be protection for lowest income elderly people.

The SMI premium could then be lowered to as little as $4 a month for either all elderly or those who are less than twice the poverty line, with increasing amounts of payments for premiums for higher income elderly. Both these strategies would reduce the fiscal pressures on the budget by reducing the amount of subsidies currently being paid. But the second strategy with the higher deductible would encourage the elderly to seek out plans that provide Medicare services in a more cost-effective manner.

It would be desirable to set the combined Medicaid and Medicare subsidy for part B at a level which covers the full costs of the most cost-effective plans in an area, so that even the lowest income Medicare elderly can be encouraged to seek cost-effective care.

There are other strategies which would encourage more cost-effective part B use, such as sharing any savings that result from the elderly using services provided at levels below current Medicare payments and possibly using competitive bid prices where that makes sense.

Medicare is a large and complicated program, and despite the many changes that have been made during the course of the last 12 years, expenditures continue at rates that are unsustainable in the future. No single change will solve all of the program's problems. A better targeting of part B subsidies is a reasonable start, both on grounds of equity, as well as efficiency. But eventually more changes will need to be made to produce a fair and efficient program.

Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY
PROJECT HOPE

Mr. Chairman and members of the subcommittee, thank you for inviting me to speak before you today. My name is Gail Wilensky. I am a Senior Fellow at Project HOPE, an international health education foundation, but I am here today representing only my own views on Medicare reform. My testimony should not be regarded as representing an official opinion of Project HOPE.

I know that you are in the middle of a series of hearings on Medicare, and commend you for the review that you are undertaking. It is important to consider Medicare in its entirety, although I recognize that today's hearing focuses on Part B reform. It is important that whatever changes are made to the Medicare program are made with the long term objectives and goals of Medicare reform clearly in mind.

The Need For Reform

Medicare is in serious need of reform. Part A, funded by the HI Trust Fund, is running out of money. According to intermediate assumptions, the latest Trustees report projects that the HI trust fund will be in deficit in the year 2001. While Part A does not have the immediate impact on the deficit of Part B, the need for change is clear and unmistakable.

Part B, which is financed three-quarters by the general fund and one-quarter by premium payments from the elderly, poses a different set of problems. It is not a trust fund which is being drained of resources, but rather the Federal budget that is being adversely affected. At a time when spending in the private sector has slowed dramatically, the increases in spending for Medicare continues in double digits.

Between 1983 and 1991, Medicare spending grew more slowly than spending did in the private sector. But since 1991 Medicare has grown substantially faster than spending in the private sector, 6.5% versus 4.7% growth in real spending, per capita. The differential spending rates appear to be even more dramatic for 1993-1994, with spending in the private sector increasing at a rate of 2.5%, while spending for Medicare increased at a rate exceeding 10%.

According to the Congressional Budget Office baseline estimates, Part B growth for fiscal year 1995 is 10.9%, with growth rates between 12%-13% per year for the remainder of the decade. Even growth rates in spending for the physician component, which in this fiscal year is projected to grow slightly less than 6%, are projected to grow between 9% and 12% per year throughout the rest of the decade. Growth rates for durable medical equipment, laboratories, out-patient hospital spending, and other Part B spending are projected to grow even more rapidly.

We shouldn't be surprised at this outcome. There are few incentives for the elderly to seek cost-effective providers, or for their physicians or medical suppliers to limit the spending on services provided to the elderly. This is particularly a problem for hospital outpatient spending and clinical lab procedures, but it is also a problem in your efforts to moderate physician spending. An individual physician's behavior has little bearing on the changes in fees to that individual that results because expenditure goals are either met or not met. This, combined with the cost-increasing incentives inherent in á la carte fee-for-service medicine, means there are few incentives for physicians to practice cost-efficient and prudent medicine, and no rewards for those that do.

Potential Strategies For Reform

Effective reforms will need to change the basic incentive structure associated with Medicare. Currently there is no incentive for the elderly to seek cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories or outpatient hospitals. Similarly, hospital are encouraged to increase the use of outpatient admissions and procedures, and physicians are rewarded for doing more when less might be as good or better. Ultimately we need to reward the elderly for choosing more cost-effective health care, provide incentives for physicians and hospitals to order and prescribe the cost-effective medicine, and be willing to share the savings which an aggressive reorganization of health care can produce. I believe that the use of a better designed Adjusted Average Per Capita Cost (AAPCC) payment, the payment currently used for capitated plans, could become the basis of a voucher or another vehicle (i.e., Medicheck) which would encourage such cost-effective choices. It would require redesigning the determinants of the AAPCC to make it more stable and take better account of the risk-selection that now appears to occur, and also opening up more choices towards which the payment can be made. Specific changes that I would recommend would include the following:

- Allow Medicare-Select to be available everywhere.
- Allow point of service plans.
- Allow partial capitation or risk-based carve-out plans.
- Move to an annual open enrollment period for all changes in Medicare related policies; discontinue 30 day disenrollment policy for HMOs.
- Remove 50/50 rule for HMOs serving Medicare beneficiaries; require outcomes based reports plus consumer satisfaction measures.
- Allow HMO'S to price underneath the Medicare payment and rebate savings to the elderly.
- Refine/revise capitation rate.
    - Break link to fee for service spending;
    - Experiment with basing Medicare's contribution to the premium on a competitively bid level; use this amount as Medicare's contribution for fee for service plans as well;
    - Experiment with alternative calculations of a capitation payment for areas that can't support competitive bids;
- End tax-exempt status of employer provided supplemental plans and end subsidy to Medigap plans.

In the short term, however, it is possible to make changes that will move the Medicare system toward a better direction. Targeting the subsidy associated with Part B, so that it is more focused on lower-income elderly, and so that it encourages a more cost-effective choice of plans, would begin to move us in a better direction than we are now going.

There are several ways in which this could be done. One strategy is to keep the structure of the Part B premium as it is now for poorer and middle income elderly, and to gradually reduce the subsidy from its current level of 75% to a 25% level for upper income elderly. The reduced subsidies could begin for individuals with incomes of $50,000, $75,000, or $100,000, depending on the perceptions as to where reduced subsidies should begin and the revenue needs of the Congress. Proposals of this nature were included in the previous two sessions of Congress.

A second strategy is to increase the Part B deductible to $1,000 from the current level of $100. This would represent the $50 deductible, originally established in 1965, indexed for medical inflation. The Qualified Medicare Beneficiary (QMB) program and regular Medicaid payments for the poor elderly would protect the lowest income elderly from the impact of this increase in the deductible. The SMI premium could be lowered to $4 a month for all elderly that are less than twice the poverty line, with higher income elderly paying increasingly higher premium levels.

Both of these strategies would reduce the fiscal pressures on the budget by reducing the amount of subsidies currently being paid. The second strategy would also encourage the elderly to seek out plans that provide Medicare services in a more cost-effective manner, but would allow those who are able and willing to choose more expensive care to do so. It would be desirable to set the combined Medicaid and Medicare subsidy for Part B at a level which covers the full cost of the most cost-effective plans in an area, so that the lowest income Medicare elderly can also be encouraged to seek more cost-effective care.

There are other strategies which would encourage more cost-effective use of Part B services, such as sharing any savings that result from the elderly using services provided at levels below current Medicare payments, and possibly using competitively bid prices for those services where competitive bids make sense.

Medicare is a large and complicated program, and despite the many changes that have been made during the course of the past 12 years, expenditures continue at a rate that is unsustainable in the future. No single change will solve all of the program's problems. A better targeting of Part B subsidies is a reasonable start, both on grounds of equity as well as efficiency, but eventually more changes will need to be made to produce a fair and efficient program.

Chairman THOMAS. Thank you very much, both of you, for your testimony, especially the succinct review and then concrete suggestions. We often wind up agreeing on the problem, without having anyone present options as to solutions.

The gentleman from Louisiana will inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank both of you for your excellent testimony. As the Chairman said, we do appreciate the concrete suggestions that you offered us.

I know we are not here to talk about health care reform in general, but it seems to me that with a couple of your suggestions we would need to put in place some sort of medical malpractice reform before those types of suggestions could be taken seriously. Do you agree with that, either of you or both of you?

Ms. WILENSKY. I think that this is an important addition that we need to consider. We now have powerful drives in place because of concerns about product liability as well as malpractice liability, that lead physicians in hospitals to do more, when less may be as well, in order to protect themselves legally.

I think there has been some very interesting legislation that has been drafted in the last few years by Members of the House and the Senate, particularly those that fundamentally change the way malpractice and product liability would occur, and I think it is something that we ought to consider, if not part of the Medicare changes, as an accompaniment that needs to occur which will also benefit the Medicare program.

Mr. BUTLER. I think it is also true that there are other areas that one would have to explore, as you do with health care reform generally, such as insurance rules and so forth. If you are encouraging people to take a Medicheck or some payment and to shop around among different plans, then there are issues associated with how rates and premiums are set.

If you have a fixed payment irrespective of age of people, then there are going to be problems of adverse selection. So there are a number of issues you have got to look at. But these are the same issues, it seems to me, that you have got to look at for general health care reform.

I think part of what we are arguing is that one must see Medicare reform as part of a general approach to health care reform in this country and apply essentially the same principles, moving away from a price control regulated system in Medicare toward one where individuals have an incentive to look for choice, and also one in which providers of plans and designers of plans have a wide degree of freedom to innovate, particularly in the Medicare case, to begin simply to catch up with the private sector in terms of what is available. That is the way to get long-run reductions in the costs of the Medicare system.

You have got to make some short-term changes, as we all know, to meet budget requirements, but we should just make sure that those are compatible. But the long-run savings are achieved through structural reform, not through tightening up the existing system.

Mr. MCCRERY. I agree that it would be difficult for us to encourage or to use incentives for physicians to do less without some backup on medical malpractice, because I do not think you get the results we desire if we did not do that.

In all this talk about means testing or income relating part B, I did not hear either of you in your oral testimony—I have not had a chance to read your written testimony—talk about part A. In fact, it is already income related, is it not, to a great extent?

Ms. WILENSKY. Well, it is partly in place now in that the Medicare portion of the wage tax that is financing part A occurs without limit on the income base which provides some relationship to income. It is important, though, for people to understand that what they receive from the part A trust fund is far greater than anything they ever put in.

Even if you count the employer contribution as part of the individual's contribution, somebody who is retiring as late as the early nineties can expect to take out two and a half times more than they have put in. So it is true that the way it is financed provides for some built-in income relationship, but it is important for people to understand there is a lot of money being transferred between the currently working and the currently retired population in part A that is going to come back to haunt all of us.

Mr. MCCRERY. Will that continue to be true in the outyears? I know you have said through the nineties, but we just lifted the cap just a couple of years ago, so eventually will that——

Ms. WILENSKY. No, that will still continue to be true.

Mr. MCCRERY. It will continue to be so?

Ms. WILENSKY. In fact, it is part of the problem that we face with the financial insolvency of the trust fund. It did not matter so much when we had fewer users relative to the payees of the trust fund, the wage earners, that people were taking more out than was being put in. But as those demographic dynamics have changes, it is tipping the fund into insolvency. So it is going to continue to be a problem, just less of a problem than if limits had not been eliminated.

Mr. MCCRERY. Mr. Chairman, my time is up, but——

Chairman THOMAS. If you want to continue, go ahead.

Mr. MCCRERY. Briefly to kind of wrap up this point. Even though part A is subsidized by general revenues——

Ms. WILENSKY. By the working population.

Mr. MCCRERY. By the working population. There is at least in part A some relationship to income in terms of what a person pays into the system. Whereas, in part B there is no relationship. So it would seem to make some sense if we have chosen that in part A to also apply that to part B to some extent, would it not?

Ms. WILENSKY. Of course, there is also the different precedent of Social Security in terms of including part of the Social Security payment as taxable income which also income relates that social insurance program, as well.

Mr. BUTLER. I think it is important also to recognize that there are fewer issues associated with part B than part A. In part A, one is contributing through one's working life and it is essentially a service which you have been mandated to pay for. Part B is an option and a voluntary system. Therefore, it seems to me that, in terms of fairness and equity, there is less concern about addressing part B in terms of the payment schedule and the premiums than there would be in changing part A, even though a strong case can be made for changes in part A as well.

Mr. McCrery. As a matter of fact, Mr. Chairman—and, Ms. Wilensky, you correct me if I am wrong—as of the years 2001 and 2002, if we do not make any changes in Medicare part A, we will have to start subsidizing it with general revenues.

Ms. Wilensky. Right, the fund will be bankrupt.

Mr. McCrery. Thank you.

Chairman Thomas. Mr. Ensign.

Mr. Ensign. Thank you, Mr. Chairman.

Just to follow up on what Mr. McCrery said, I think that our Social Security system, as well as with our Medicare system, because it was not set up like an annuity type of a program, is almost like a pyramid scheme where at some point the people that are in at the beginning benefit, but the people that come too late pay the cost. People my age certainly are not looking forward to Social Security some day. They are not looking forward to Medicare being there some day. Obviously, unless some pretty severe and drastic changes are made to those systems, I do not think that they will be around in 30 to 40 years.

My question—and either one of you feel free to address—is about incentives in the system, having talked a little about Medisave accounts for the general population. Could you address whether you think Medisave accounts would work as well? If we did go to the Medisave accounts for Medicare, what level would those Medisave accounts have to be to provide the proper incentives for people to shop?

Ms. Wilensky. Well, it depends on how you want to structure it. One of the concerns with Medisave, where you have some pretax dollars set aside for health care, is self-selection or adverse selection, whether some of the sicker people will find themselves in a difficult position, unable to finance their insurance purchase and their medical purchases.

If you think about the average payment that we use for HMOs or the Medicheck concept as being an amount that can buy an insurance plan, an average insurance plan, but one for which you can receive refunds or rebates, there really is a very natural linkage to the Medisave logic. That is, a person could buy a more catastrophically oriented health care plan, receive a rebate, a savings over what that smaller coverage would cost and be able to have that amount of money available for the direct purchase of health care.

It is just one of the many ways that this concept encourages people to buy what makes sense for them, to look at the best buy they could get for whatever amount of insurance they want to purchase and to use any additional moneys that may be available for other potential health care spending that may not be covered by Medicare or to have in the future, in case they have higher needs sometime in the future.

Mr. Ensign. Do you know what level that would have to be, that Medicheck, what kind of a subsidy would be required per person?

Ms. Wilensky. I do not, but it is a calculation that would be based in part on what the cost of a catastrophic plan would be and then how much you want to subsidize the spending up to the catastrophic plan, and whether you want that to be equally subsidized, no matter who you are. You may want to make the amount either greater for greater health risks or greater for poor people.

But it is really the concept of do you want to move away from a heavily insured system or to have one where you have choice. Once you make that decision, technical policy advisers like us can design a plan that will meet your needs and meet your revenue.

Mr. BUTLER. I think one caveat I would want to emphasize is a Medisave component added to the current structure of a heavily regulated fee-for-service system only gets you a very small part of the way. It is very important to bring about a reform that allows very different methods of getting health care, everything from managed care to other things we have not even imagined yet. Simply to have a catastrophic Medisave version of what is currently in place is but a very small reform. You have got to think much beyond that.

Ms. WILENSKY. One of the major problems we have now is that the elderly, unlike the rest of us, have very little option in terms of what they can buy. The evolving, innovative delivery structures are just not available to the elderly. They can buy a very traditional, rigid HMO or they can stay in the sixties organized medicine that Medicare has always been. There is nothing inbetween that has been available, except for 15 States that used to have a preferred provider option, but even that authority has now run out.

So I agree very much with Stuart Butler, it is changing the design so that this is an option compatible with the other changes to make the elderly both more cost conscious and to give them rewards when they are—and to also reward their physicians and hospitals who provide cost-effective care.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Senator Kerrey in his testimony I thought indicated a number of clear directions that we should go, one, lower the rhetoric so that we can create a bipartisan structure. But he also referred to a timeline in terms of perhaps we do not need to move forward quite as rapidly as some folks think.

I guess I am trying to put together the comments of the gentleman from Louisiana and your response, if we do nothing, part A is going to expire by 2001 approximately. And since we have removed any income limit, the only thing left is to raise tax rates, and that even skews the unfairness even more in terms of the high income paying into a plan for which literally they may not get the benefits out of it that they pay into it, contrary to Social Security now in terms of how much you get out of it versus what you pay into it.

I am just wondering if you share the timeline—I do not want to call it time limit complacency—I guess I do not, and I need to know if you folks think that I am pushing it too much to say we need to put in place some mechanisms in the 104th Congress. Because I believe we have a relatively enormous education process that we need to carry out, and perhaps that is going to be the most difficult thing. Any reaction?

Ms. WILENSKY. There are several points to make about that. First is that 6 years is not very long, no matter what, and then we are in serious trouble—the Congress and the country is in serious trouble in 6 years. The second thing is, if you are looking for revenues from savings from this program, you want to be sure any changes that you make move you in the right direction and do not further complicate the issue.

Third, the sooner you start changes and moving in the direction you want to go, the wider your options, and the fairer in terms of signaling to people what they can expect when they get to be 65 years old. So technically you are not absolutely with your back against the wall in 1995. But, the sooner you start making these changes, the better the Medicare system and the fairer these changes will be.

Mr. BUTLER. I think also it is very important not to wait until the tidal wave engulfs us. The kind of changes we are suggesting, in terms of restructuring the system, will lead to cumulative savings over time. They are changing the basic dynamic of the system such that you begin to rack up savings over time.

If you wait until the crisis is upon you, then you will not get the big savings up front from implementing then what we are talking about now. Then you will tend more likely to put into place bad policies, tighter controls, more restrictions, forcing the elderly into plans they do not want. So I think it is very important that you begin a process where the payoff is down the road, but it is very substantial and in line with greater freedom and opportunity and innovation. So I would encourage you very much to move quickly to begin to put into place the kind of structure now that will be in place to avoid the crisis that otherwise is going to engulf you.

Chairman THOMAS. Let me come full circle so, as we finish this panel, I understand. We have not been talking about part A because of the funding mechanism. It is the part B which, as you correctly point out, Dr. Butler, is voluntary, but you wonder who would not voluntarily join up to a system that is going to give you 75 cents on the dollar, regardless of your income.

Mr. BUTLER. Mr. Chairman, it is what one might call "a steal."

Chairman THOMAS. A steal, rather than voluntary. However, there is going to be some political expense to make this change. We heard, for example, from Joint Tax that a reasonable structure would produce around an $8 billion amount. Obviously, you would get some behavioral reinforcement for the change.

My basic question would be, notwithstanding the desirability to do this for either revenue or behavioral changes, is it worth doing in the short run, when we are trying to keep our eye on that fundamental reform, and perhaps we could bring about a more balanced relationship between government goods and services and wealth in the fundamental reform, or is it one of those preconditions to making it easier to move into that reform, that is, should we do it or should we not, from a political and a policy point of view?

Mr. BUTLER. You are under two broad pressures, Mr. Chairman. Mr. Kasich is looking for all kinds of ways to achieve the objective of a balanced budget, and that is quite proper.

Chairman THOMAS. I thought we could close the doors on that for just a little while and talk about——

Mr. BUTLER. But it is a reality. It is a reality and, therefore, when you look at Medicaid, you want to put into place some changes which do contribute to that budget objective, but certainly do not conflict with the longer run objective of Medicare reform. Whatever savings one can get now that are politically achievable makes sense. But I think what is crucially important, that whatever you do in terms of savings, whether it is $8 billion or more than that, must be combined with steps to deal with the real problem which is coming down the pike.

Ms. WILENSKY. Let me push you to go further, in part because I think that you will have to consider how much political capital you have to make these changes and how many times you can make them.

I agree that you will need some revenues in this Congress and you may not have the luxury of ignoring that need. But there are ways to partially or fully set in place the kinds of changes we have talked about, and I strongly encourage you to do those in this Congress, as well, such as to allow partial capitation or risk-based carve-outs, to have HMOs allowed to price beneath the Medicare payment and rebate savings to the elderly, to revise and refine how you do the capitation rate, breaking the link to fee-for-service spending in Medicare and tying it to a more reasonable rate of change, to look at the notion of having Medicare's contribution to a premium be based on a competitively bid level, at least on an experimental basis in places that make some sense, to use an outcomes based measure for quality and to include consumer satisfaction, rather than the current 50/50 rule requiring 50 percent commercial enrollees, as well as no more than 50 percent Medicare, and to change the nature of the enrollment period from this continuous 30-day enrollment/disenrollment to a onetime waiting period and then annual enrollment like the rest of us have.

Those kinds of changes are changes that could be introduced in the 104th Congress and that would begin to substantially change to this Medicheck or capitation oriented system, as well as to have some means testing components. So if you think that you can have the support of your committee members to go forward, I would strongly encourage you to have broader visions than only income relating part B.

Chairman THOMAS. I think that is basically the argument that any change is resisted, and that if you do a simple thing like means testing or income relating, you are going to get a degree of opposition. You might as well move as boldly as you can to get as many of these pieces in place, including this, because you will get resistance anyway. I think that is ultimately the political answer.

I appreciate your specific suggestions and, as technical policy advisers, we look forward to seeking your advice on technical policy changes. Thank you very much.

Ms. WILENSKY. Thank you, Mr. Chairman.

Mr. BUTLER. Thank you, Mr. Chairman.

Chairman THOMAS. Now we would ask the last panel if they would come forward: Jay Hopkins, Medicare policy analyst, Seniors Coalition; Martha Phillips, executive director of the Concord Coalition; Margaret Dixon, president-elect of the American Association of Retired Persons; and Max Richtman, executive vice president of the National Committee to Preserve Social Security.

I will tell all of you that your written statements will be made a part of the record, without objection. You have 5 minutes to inform us in any way you see fit. I guess we will just start on my left, your right, and move through the panel.

Mr. Hopkins.

STATEMENT OF JAY HOPKINS, MEDICARE POLICY ANALYST, SENIORS COALITION

Mr. HOPKINS. Thank you, Mr. Chairman, for allowing me to testify today.

Members of the Seniors Coalition recognize that the financial viability of Medicare part B faces some very serious hurdles in the next few years. Outlays for the program have increased 59 percent in aggregate over the past 5 years. We cannot stick our heads in the sand in hope to sustain such staggering growth rates without making changes. Members of the Seniors Coalition are also acutely aware of the fact that this country is grappling with major budgetary problems. Hence, our support of a balanced budget amendment.

If approached in a different climate, we would probably not be very receptive to the idea of income testing the part B premium. But the Contract With America is helping to create a new environment for seniors. Certain contract provisions would repeal the 1993 tax on Social Security, roll back the Social Security earnings test and improve access to long-term care insurance. Given that each of these changes would give seniors more control over their money, we feel that means testing the part B premium should be given consideration as being a component of a more comprehensive solution.

Funding for Medicare part B, unlike part A, does not come from a trust fund drawn from payroll contributions from future beneficiaries. Today, more than 70 percent of part B costs are subsidized by tax dollars drawn from the Federal Treasury. Given the system's current strain, it is not unreasonable to ask top-earning beneficiaries to accept a lower subsidy level. Although the resulting savings is unlikely to produce a revenue bonanza for the system, it should be viewed as an important part of the answer.

Let me stress that income testing part B premiums should only be considered within a full range of options to repair the system's troubled finances. The Seniors Coalition strongly supports the concept of a whole market basket of Medicare choices for seniors. Medicare vouchers, Medicare savings accounts, Medicare PPOs and Medicare HMOs are among the options that merit a closer look.

In any case, our members have made it clear that they do not want bureaucratic one-size-fits-all solutions. Seniors want a range of choices that can only be offered through greater participation by the private sector.

Thank you.

Chairman THOMAS. Thank you very much, Mr. Hopkins.

Ms. Phillips, welcome in front of this committee. You may proceed in any way you see fit.

[The prepared statement follows:]

TESTIMONY OF JAY HOPKINS
MEDICARE POLICY ANALYST
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Income-Testing Medicare Part B is a Reasonable Component of a Larger Solution

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In any case, our members have made it clear that they don't want bureaucratic "one-size-fits-all" solutions. Seniors want a range of choices that can only be offered through greater participation by the private sector.

STATEMENT OF MARTHA PHILLIPS, EXECUTIVE DIRECTOR, CONCORD COALITION

Ms. PHILLIPS. It is very interesting sitting on this side of the table.

I am Martha Phillips, the executive director of the Concord Coalition. The Concord Coalition is a 150,000-member organization dedicated to reducing the deficit and thereby ensuring the economic prosperity for future generations of Americans. We look at entitlement of issues from the point of view of the overall budget deficit.

Part B of Medicare is an entitlement. When the Concord Coalition put together its "Zero Deficit Plan for the Year 2000," which we now have to update for the year 2002, a central recommendation was entitlement means testing. All entitlements should be paid according to recipients' economic means. We included part B premiums as part of that means testing proposal.

In our plan, we suggested starting means testing in the $40,000 to $50,000 income range and completing the phaseout of entitlements at $120,000 at which point 15 percent of benefits would be paid. We have tightened down on Medicare many times previously, and yet the program still continues to grow, and grow, and grow. And as part of the long-term solution to balancing the budget, the Concord Coalition is convinced that more is still needed to be done and that means testing is a fair and equitable way to do part of the job. It will not do the entire job.

We are not alone in recommending that part B be income related. As early as 1991, in his fiscal 1992 budget, President George Bush proposed that individuals with adjusted gross incomes over $125,000 and couples over $150,000 be required to pay a part B premium equal to 75 percent of program costs.

Similarly, President Clinton's health care plan and last year's Penny-Kasich budget plan both made recommendations in this general direction. Clinton suggested the part B premium for individuals over $90,000 and for couples over $115,000 be gradually increased until the beneficiary pays half of program costs. Penny-Kasich would have required beneficiaries over $100,000 to pay the full monthly premium.

I should say that the Concord Coalition feels very strongly that if we do move to means testing, that money that is saved should be used to help reduce the deficit. We are not particularly excited about using it to pay for income tax cuts at this time. We think that it is more important to solve the deficit problem first.

Some people have suggested that means testing, whether it is for part B premiums or for other kinds of programs, has a number of negative effects that you should watch out for. It is often suggested that means testing will discourage savings. That kind of puzzles me, because there are economists who have studied savings behavior over time who believe that when the creation of Social Security and Medicare came into place, it discouraged savings because people then knew they did not have to save for their old-age retirement or their health care.

Now they say, well, if you tighten down on these programs, that discourages savings. So you cannot have it both ways. In fact, we think that many older people are target savers. They are saving for a specific amount of retirement income or for a cushion against unexpected expenses. And if they know that they do not have so much safety net from Social Security and Medicare, if anything, it will encourage them to save even more.

We think that these programs can be shifted gradually and fairly and not have an abrupt negative impact on the elderly who do not see it coming. We dismiss the argument that means testing would turn these entitlements into welfare programs and, thereby, lose political support. On the contrary, I think many people would be heartened to know that their tax money was being targeted rather than squandered on benefits paid to people wealthier than they. If you started over and asked the question, “If this program did not exist, would you choose to create a program that provides so much benefit to upper-income people today”? the answer would probably be “no.”

In closing, I would like to mention that we are very intrigued with the Harris Poll that has been conducted a number of times and keeps coming up with the same answer. They asked, “For you and your family, how much income do you think it would take to live in reasonable comfort, and how much would it take to fulfill all your dreams”? They broke out the responses by age group, and for people age 60 and over, the answer for living in reasonable comfort was $25,700, and dream fulfillment came at the surprising price of $56,900. Obviously, most of these older people live outside the beltway. But if you were thinking about what is an appropriate level to begin to apply means testing, you should keep these numbers in mind.

Thank you.

[The prepared statement follows:]

THE CONCORD COALITION

1019 19th Street N.W., Suite 810, Washington D.C. 20036
202 467 6222 ◆ (Fax) 202 467 6333

STATEMENT OF MARTHA PHILLIPS,
EXECUTIVE DIRECTOR,
THE CONCORD COALITION
FEBRUARY 7, 1995

BEFORE THE HEALTH SUBCOMMITTEE,
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and Members, I am Martha Phillips, the Executive Director of The Concord Coalition. The Coalition is a 150,000 member organization dedicated to budget deficit reduction and ensuring economic prosperity for future generations of Americans.

I am pleased to be with you to share my thoughts on Supplementary Medical Insurance (SMI), more commonly known as Part B of Medicare, which pays for doctors and outpatient services. Over 35 million aged and disabled Americans are enrolled in Part B. As this subcommittee searches for budget savings in the Medicare program as part of your cost-cutting and reform efforts, I would urge you to examine the nature of the Part B premium subsidy.

Currently, beneficiaries pay only about one-fourth of program costs; the remainder comes from general revenues. The question this subcommittee should ask is: should wealthy families continue to have their Medicare premiums subsidized by other taxpayers, including many taxpayers with far lower incomes.

According to the Congressional Budget Office, a substantial percentage of families with higher incomes currently receive Medicare benefits. In 1990, the CBO found that twenty percent of families with incomes above $150,000 received Medicare benefits.

As the Members of this Subcommittee well know, the Medicare program--both Part A and Part B--has long been a concern. Total Medicare outlays increased from $32 billion in 1980 to $131 billion in 1993, an average annual growth rate of 11.5 percent. Projections are that Medicare growth has slowed, but is expected to continue above nine percent. Medicare is now a full ten percent of the Federal budget.

This Subcommittee took a number of actions during the 1980s to slow the growth of Medicare spending, culminating in the most recent changes in the 1993 budget reconciliation, which together reduced the projected growth in spending in Medicare by a total of $56 billion for Fiscal Years 94-98. These reductions were achieved largely through reduction in inflation allowances for provider reimbursement, along with a continuation of the current policy of setting the Part B premium at a level to cover 25 percent of program costs.

In 1993, following enactment of President Clinton's budget plan, the Concord Coalition put out a "Zero Deficit Plan" to complete the unfinished work of balancing the budget. This plan illustrated what a fair, balanced, gradual implementation of a balanced budget would look like. In the Zero Deficit Plan, The Concord Coalition recommended raising the enrollee share of the premium from 25 to 30 percent. An increase of five percent would mean a modest increase of about $8 to each enrollee. However, the total Federal savings of this proposal is almost $10 billion over five years.

Let me note at this point Mr. Chairman and Members that The Concord Coalition urges that any savings achieved in the Medicare program--or any other entitlement program--be reserved for deficit reduction and not spent paying for any tax cuts.

The Zero Deficit Plan also recommended a comprehensive means-test on all entitlement programs, including the insurance value of Medicare. We believe that means-testing the Part B premium is in keeping with this approach and we urge the Subcommittee to consider it.

As early as 1991, as part of his Fiscal 1992 budget, President George Bush proposed income-testing for wealthy enrollees. In that budget, President Bush said:

> A strong argument can be made that Part B provides benefits beyond the original intent of the program--insuring that affordable, quality care is available to seniors--by providing large subsidies to the wealthy.

President Bush went on to propose that individuals with adjusted gross incomes above $125,000 and couples with AGIs above $150,000 be required to pay a Part B premium equal to 75 percent of program costs. Similarly, President Clinton's health care plan, and last year's Penny-Kasich Budget Amendment have proposed that high-income beneficiaries pay a larger share of their Part B premiums.

President Clinton suggested that the Part B premium for individuals with over $90,000 and couples with incomes in excess of $115,000 be gradually increased until the beneficiary pays 50 percent of program costs. The Penny-Kasich Amendment would have required beneficiaries with incomes above $100,000 to pay the full monthly premium of about $150.

The Concord Coalition and its Members strongly feel the Congress should seriously consider a means-test of Medicare Part B premiums as well as other currently non-means-tested entitlements.

Mr. Chairman and Members, for our purposes today, it might be useful to examine a few of the arguments in opposition to means-testing. First, it has been suggested that means-testing would discourage savings; that people would divest themselves of their income-generating assets in order to qualify for full benefits.

Perhaps this is true for people whose target retirement income was at or below the approximate starting point for the means-test. It is probably not true for most of the people in the group of fortunate achievers who would be most affected by the means-test. In their working years, as they contemplate retirement, they probably have a target retirement income range in mind and an idea of the amount of assets it would require to achieve that income. People who desire to have, say, a retirement income of $60,000, $75,000, $100,000 or more, and understand that this would make them eligible for much less in Social Security and Medicare, would tend to save more rather than less in order to achieve their retirement income.

A second argument has been made that today's elderly should not be required to participate in such an abrupt change of policy direction because they have planned their retirements around a reliance on the existing benefit rules, and for them, it's too late to change their earning and saving patterns. But should the comfortably well-off people in this generation be given a free ride while financially struggling young families shoulder more of the burden? The essence of a means-test is to ask those most able to trim back their dependence on government benefits to do so in order that less can be required of others.

Finally, it is suggested that if the wealthy did not receive full benefits, retirement programs like Medicare would be viewed as "welfare" rather than an earned right and political support for the program would erode. The reality, Mr. Chairman and Members, is that the Medicare program is in very deep trouble, teetering on insolvency. At the same time, the working population supporting Medicare and Social Security is increasingly convinced benefits will not be available when they retire and may not for long support the burdensome payroll taxes required to continue the current program. I would argue that people would be more willing to support the system if they felt it was better targeted to those in need.

We should also ask ourselves if we were setting about not in 1965 but instead in 1995 to create a Medicare system, would we design it differently? I believe the answer is clearly yes, and if we want the system to survive another thirty years, we need to begin today to re-think many of the fundamental precepts of the programs, including whether or not wealthier Americans should be required to pay a larger share of their Medicare program costs.

In closing Mr. Chairman, I am reminded of a recent Harris Poll that asked Americans sixty years of age and older, how much income they needed to live in "reasonable comfort." The answer may shock you: $25,700. When asked how much income they would need to "fulfill all their dreams," the answer was $56,900. Knowing that, makes asking seniors with high-incomes to sacrifice somehow easier to do.

The Concord Coalition urges the Subcommittee to be bold and to be innovative. We believe the American people will support you if you make some tough choices. Requiring high-income beneficiaries to pay a little more of the cost in providing their health insurance is not only equitable and fair, it can be part of the solution that saves the Medicare system for future retirees.

Chairman THOMAS. Thank you very much, Ms. Phillips.
Ms. Dixon.

STATEMENT OF MARGARET DIXON, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. DIXON. Thank you.

I am Margaret Dixon, president-elect of AARP. I appreciate the opportunity to come before you to discuss the impact of income relating the Medicare part B premium. AARP opposes requiring an income related part B premium in the absence of health care reform that includes systemwide cost containment and some new benefits to cover the extraordinary out-of-pocket costs that beneficiaries face for uncovered services like prescription drugs and long-term care.

Without adequate control over systemwide spending, we believe that a new premium on high-income beneficiaries is nothing more than a cost shift. We also question the equity of singling out older persons, while continuing Federal health care subsidies for other Americans. It is one thing to propose progressive financing for health care; it is another thing altogether to support a seniors-only tax.

Older persons already spend more out of pocket for health care than any other age group. In 1995, older Americans will spend over $3,000 out of pocket for health care services and premiums, not including what they will have to pay for long-term care. Increasing the part B premium will only drive these out-of-pocket costs higher.

Imposing an income related premium is really nothing more than a shell game. It places an additional tax on the very people who are supposed to be helped by the Contract With America's provision to eliminate the 85-percent taxation of Social Security benefits. Moreover, the beneficiaries most affected by an income related premium are those who have already paid more into the part B program through Federal income taxes throughout their lives, and they continue to do so.

If Congress believes that income relating premiums is a good idea for the elderly, then private sector premiums for those under 65 should be income related as well. Savings to the Federal Government generated by reducing the tax break for employer provided health insurance for higher income workers would far exceed the increased revenues from the part B high-income premium. It does not seem fair for taxpayers to continue to subsidize corporate CEOs or Members of Congress, while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced.

Many members of this committee were here in 1989 when Congress repealed another seniors-only tax. In that case, important benefits were lost as well. Some members of this committee spoke very firmly about their opposition to that tax. We see little difference between that tax and an income related premium, except that it would be considered catastrophic without the benefits.

The American Association of Retired Persons is prepared to work with members of the subcommittee to identify ways in which we can achieve systemwide control over health care costs, preserve Medicare and not result in the kinds of inequities posed by an income related part B premium.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARGARET DIXON
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Subcommittee, I am Margaret Dixon from Clinton, Maryland. I am President-elect of the American Association of Retired Persons (AARP). I appreciate the opportunity to appear before the Subcommittee today to discuss the implications for beneficiaries of income-relating the Medicare Part B premium.

AARP believes that decisions about whether beneficiaries should be required to pay more for Part B ought to be the outcome of careful policy deliberation about what is in the best interest of the Medicare program and its beneficiaries -- rather than a hasty attempt to simply shift more costs onto older Americans.

AARP also believes that careful consideration must be given to the question of whether it is equitable to single out older persons by requiring them to pay a significantly higher proportion of health care costs while continuing full federal health care subsidies for working Americans of all incomes. Currently, 75 percent of Medicare Part B costs are paid out of general revenues; Medicare beneficiaries pay the remaining 25 percent of Part B costs. Part A costs are funded by payroll taxes and are paid out of the Hospital Insurance (HI) Trust Fund. Thus, Medicare beneficiaries during working and retirement years pay 70 percent of the cost of Medicare benefits. General revenue contributions represent only about 30 percent of total Medicare costs. By contrast, Members of Congress and federal workers receive on average a 72 percent subsidy for their health insurance. In addition, employer-provided health insurance premiums are exempt from taxation. It is one thing to propose progressive financing for health care, it is quite another to support a "seniors only" tax.

The Medicare Part B Premium

Medicare Part B is financed from two sources -- general tax revenues and beneficiary premiums. Currently, all Medicare Part B beneficiaries pay the same monthly premium -- $46.10 a month or $553 a year in 1995. The only exceptions to this rule are low-income beneficiaries eligible for the Qualified Medicare Beneficiary (QMB) program whose premiums are paid by Medicaid.

Since Medicare was enacted, the calculation of the Part B premium has been reconfigured a number of times as health care costs increased, but in general since 1982 it has been intended to approximate 25 percent.

In the early years of Medicare, the Part B premium was set at a level equal to roughly one half of program expenditures. In 1972, Congress changed the premium calculation to equal the lower of 50 percent of the aggregate program costs for aged enrollees or the prior year's premium increased by the Social Security cost-of-living adjustment (COLA). The Ways and Means Committee's rationale for this change -- as stated in the report language of the 1972 Social Security Amendments -- was the concern over the increasingly severe financial burden that the premium amount would have come to represent in future years and the ability of beneficiaries to pay it. Simply put, it was recognized that premiums would not only absorb the COLA but would exceed it resulting Social Security checks that would fall behind inflation.

In 1982, when it became apparent that health care costs were rising so much more rapidly than the COLA that the premium was dropping below 25 percent of Part B costs, Congress fixed the Part B premium at 25 percent of program costs. This change actually went into effect in 1984. In OBRA '90, Congress set fixed dollar amounts -- projected to cover 25 percent of program costs -- in statute for 1991-95.

What Older Americans Really Pay Out-of-Pocket

The concern raised by the Ways and Means Committee in 1972 remains valid today. The Part B premium, coupled with other out-of-pocket spending, constitutes a very significant proportion of an older person's income. An increase in the Part B premium would mean that an even greater portion of retiree income would be eroded.

In 1995, older Americans are projected to spend over $3,000 for out-of-pocket health care services (including physician, hospital, drug, home health and durable medical equipment) and premiums. This amount does not take into account the cost of institutional care that drives out-of-pocket spending even higher. By the year 2002, out-of-pocket costs for older Americans are projected to increase to over $4,600. Assuming no changes in policy, over the next seven years -- between 1996 and 2002 -- older persons are projected to spend nearly $27,400 out-of-pocket for health care expenses. As a percent of income, older Americans spend about three times as much on health care expenses as younger Americans.

Just for Medicare alone, beneficiaries pay sizable out-of-pocket expenses in 1995 including:

- **Part B Premium:** Monthly premium of $46.10
- **Part B Deductible:** A $100 annual deductible for Part B services
- **Part B Coinsurance:** 20% coinsurance for most Part B services; coinsurance in excess of 50% for some outpatient services
- **Hospital Deductible:** One deductible of $716 per hospital admission (Re-admission within a 60-day period does not trigger another deductible)
- **Hospital Coinsurance:** For the 61st through 90th day of hospitalization ($179 per day); and from the 91st through the 150th day of hospitalization ($358 per day)
- **Skilled Nursing Facility (SNF) Coinsurance:** Daily coinsurance for the 21st through 100th day of SNF care ($89.50 per day)

Medicare beneficiaries are also faced with additional out-of-pocket costs for necessary services not covered by Medicare including:

- **Outpatient Prescription Drugs:** Beneficiaries are responsible for all outpatient prescription drug costs
- **Hospital Coverage Beyond 150 Days**
- **SNF Care Beyond 100 Days**
- **Daily Home Health Care Beyond 2-3 Weeks**
- **Long -Term Nursing Home, Adult Day Care or Respite Care Services**
- **Inpatient Psychiatric Care Beyond 190 Days**
- **Balance Billing:** Additional physician charges up to 15 percent over Medicare's reimbursement
- **Preventive Care Services:** Costs of routine physical exams, colo-rectal and prostate cancer screening, routine foot care and most immunizations
- **Cost of hearing aids and eyeglasses**

Imposing A High Income Part B Premium Is Merely Cost-Shifting

AARP has opposed increasing the Medicare Part B premium for higher income beneficiaries outside the context of health care reform. In the absence of comprehensive reform which would control health care costs throughout the system, a high income premium would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending. Depending on where the thresholds are set for who is "higher income" initially or over time, many middle income elderly could find themselves paying significantly higher Part B premiums. This would be similar to the history of Social Security taxation. The initial thresholds for taxation of Social Security affected 8 percent of beneficiaries but because they were not indexed now affect 25 percent of beneficiaries.

Moreover, imposing an income-related premium is really nothing more than a shell game. It places a comparable tax burden on the very people who are supposed to be helped by the Contract With America's provision to eliminate the higher, 85 percent taxation of Social Security benefits.

Ironically, the beneficiaries most affected by an income-related premium are the individuals who have already paid more into the Part B program through federal income taxes throughout their lives -- and continue to through the taxes they pay today.

If Congress believes that income-relating premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country. If the Part B premium is income-related, then other public and private sector premiums for the non-Medicare population should be income-related as well -- including those of Members of Congress. In fiscal year 1995 alone, the federal government was estimated to have lost **$56 billion** by providing tax breaks for employer-paid health care premiums.

Is it fair that taxpayers would continue to subsidize the health care premiums of a corporate CEO with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced? AARP estimates that income-relating the tax subsidies for private insurance premiums in the same manner as has been proposed for a higher income Medicare Part B premium would raise about $20 billion between 1996-2000. (See Chart I)

Conclusion

Mr. Chairman, many members of the Committee were here in 1989 when Congress repealed another "seniors only" tax. In that case important benefits were lost as well. Indeed, some members of this Committee spoke very firmly about their opposition to that "tax." Aside from a higher threshold, we don't see the difference between that tax and the income-related premium being discussed today -- except that it would be considered "catastrophic" without the benefits.

Rather than beginning to bring health care costs under control, income-relating the Part B premium simply shifts the burdens to older Americans. Rather than addressing cost containment throughout the system, it singles out older persons by requiring them to pay a significantly higher proportion of health care costs out-of-pocket than other Americans.

The Association is prepared to work with you and the members of the Subcommittee on identifying ways in which we can achieve systemwide control over health care costs that will preserve Medicare and not result in the kinds of inequities and cost-shifting posed by an income-related Part B premium.

Chairman THOMAS. Thank you very much, Ms. Dixon.
Mr. Richtman.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Thank you, Mr. Chairman.

The National Committee to Preserve Social Security and Medicare appreciates the opportunity to testify about the Medicare part B premium, which most of our members pay. The National Committee strongly opposes means testing the Medicare part B premium.

The Federal Government helps to guarantee health security to millions of Americans through Medicare, Medicaid and health insurance tax subsidies. Medicare should not be singled out for means testing. Means testing the Medicare part B premium also undermines Medicare as an insurance program.

Our testimony, which draws on research by Lewin-VHI in health care insurance tax subsidies and Medicare benefits, which we have forwarded to the subcommittee, will discuss four reasons why the part B premium should not be means tested.

First, adding a means test to Medicare, which is already progressive, we believe is excessive. The Medicare payroll tax is a flat percentage of earnings, currently 1.45 percent. The higher the earnings, the more tax is paid. Benefits, on the other hand, are generally the same for everyone, regardless of income. Consequently, higher income beneficiaries pay more than lower income beneficiaries for the same benefits.

Beginning in 1994, the payroll tax was applied to all earnings, rather than up to a specific limit. The Medicare part B subsidy for upper-income beneficiaries will be more than made up by Medicare part A taxes in excess of part A benefits. Future high-income beneficiaries, as our study shows, will receive on average $159,000 less in Medicare part A and B benefits than they will pay in taxes and premiums over their lifetime. Higher income beneficiaries will, in effect, subsidize lower income beneficiaries.

Congressman McCrery, I believe you asked a question of one of the previous witnesses who was testifying about how quickly the benefits are retrieved. In fact, I think her response was incorrect. I think that may have been true, as you pointed out, up until the point the cap was lifted, and prospectively that statement is no longer accurate that the previous witness made. I would like to clarify that.

Second, the Medicare part B premium should not be singled out for means testing, especially when Medicare as a whole is progressive. The government promotes health insurance coverage through health insurance tax subsidies to working Americans worth $46 billion in 1994. These health insurance tax subsidies are more valuable to higher income individuals. Over a working lifetime, these subsidies add up for upper-income working families. Under current law, lifetime health insurance tax subsidies for upper-income families are 10 times more valuable than the lifetime tax subsidy for low-income families.

Many Members of Congress would like to improve the health insurance tax subsidy for the self-employed. It would be ironic, we think, if the Medicare premium was increased for upper-income beneficiaries, at the same time that the health insurance tax subsidy was increased for equally wealthy non-Medicare beneficiaries.

Third, means testing the part B premium we think tinkers with the insurance design of Medicare and undermines its political support. Eventually, high-income beneficiaries would question whether Medicare as an insurance program would be cost effective, and wonder why they should pay high taxes to support it, when they receive little or no benefit. Disenrollment of high-income beneficiaries also could increase premiums for other beneficiaries, if most of those who disenroll have lower health care costs on the average, which I think most people believe to be the case.

Finally, this proposal we think is budget driven. Savings will be short lived, however, unless the factors that are driving both public and private sector health care cost increases are controlled. This shortsighted budget policy to reduce Medicare coverage we think is bad health policy. Seniors are thankful for Medicare health insurance but no one should exaggerate its generosity.

The bottom line is that today Medicare pays less than half of seniors' health care costs, including long-term care. Total out-of-pocket health care costs are a larger percentage of income now than when Medicare first started. I want to reemphasize that. Seniors today on Medicare pay more out of pocket as a percentage of income than before we had Medicare. I think people need to understand that in the context of some of the myths about senior citizens that we hear over and over again.

In conclusion, it is understandable for Congress to hold hearings on this controversial proposal in its effort to find savings. However, we hope that our testimony will help guide the committee away from this tax increase for higher income seniors. Congress should be very careful about altering the insurance design of Medicare by means testing Medicare part B premiums. If necessary, the wealthy can take care of themselves. But if support from the wealthy for Medicare erodes, it is the poor and the middle class who will suffer.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF MAX RICHTMAN
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare, a grassroots advocacy organization representing millions of Americans. The National Committee strongly opposes any proposal to means test the Medicare Part B premium. The federal government helps to guarantee health security to millions of Americans through Medicare, Medicaid, and health insurance tax subsidies. Medicare should not be singled out for discriminatory treatment by means testing the Part B premium. Means testing the Medicare Part B premium also undermines Medicare as an insurance program. It is not necessary to make Medicare more progressive since it is already progressive, more so than health insurance tax subsidies.

Our testimony will discuss four reason why the Part B premium should not be means tested. It will draw upon research by Lewin-VHI on "Health Care Insurance Tax Subsidies and Medicare Benefits". See Appendix I for an Executive Summary is attached.

First, making Medicare more progressive is excessive. Congress has already acted to make Medicare more progressive by raising the taxable wage base for Medicare payroll taxes in 1990 to $125,000 and eliminating the wage base altogether in 1993. Looking only at the general revenue subsidy for Medicare Part B ignores the total picture. The Medicare Part B subsidy for upper income beneficiaries will be more than made up by Medicare Part A taxes in excess of Part A benefits. Future high income beneficiaries will receive on average $159,000 less in Medicare Part A and B benefits than they will pay in taxes and premiums over their lifetime, according to a study by Lewin-VHI commissioned by the National Committee. Higher income beneficiaries will in effect subsidize lower income beneficiaries.

Second, Medicare and Medicaid are not the only government programs providing health security for Americans. The government promotes health insurance coverage through health insurance tax subsidies to working Americans. These subsidies, however, are more generous to high income workers than any Medicare "subsidy" received by high income seniors, according to Lewin-VHI. The Medicare subsidy should not be singled out for different treatment. All subsidies should be treated in a similar manner. We have attached a copy of the Lewin-VHI study to our statement.

Third, means testing the Part B premium tinkers with the insurance design of Medicare and undermines political support. A premium as high as three times the current Medicare premium would discourage many high income beneficiaries from enrolling in Medicare Part B. High income beneficiaries are generally healthier and private insurance, if permitted, would be very competitive. Eventually, high income beneficiaries would question Medicare as an insurance program and wonder why they should pay high taxes to support it when they receive little or no benefit.

Fourth, the real reason for this proposal is to raise revenue because of the failure to enact health care reform with effective cost controls on both the private and public sector. The rapid cost increase for Medicare only mirrors health care cost increases in general. Only comprehensive reform with cost controls will change the long-term trend. Medicare beneficiaries already pay as much if not more in premiums for health insurance than individuals with employer provided health insurance and employer plans are more generous than Medicare.

Medicare Progressivity

One might think that high income Medicare beneficiaries receive a great deal if one looked only at the general revenue subsidy for Medicare Part B. Distinctions between Medicare Part A and B are quite artificial, however. Beneficiaries qualify for Medicare Part A through payroll tax contributions during working years. The payroll tax is a flat percentage of earnings, currently 1.45 percent. The higher the earnings, the more tax is paid. Benefits on the other hand are generally the same for everyone regardless of income. Consequently, higher income beneficiaries pay more than lower income beneficiaries for the same benefits.

While Medicare has always been progressive, Congress has made Medicare more progressive. Prior to the 1990s, the Medicare payroll tax was payable on earnings only up to the maximum wage base for Social Security contributions which was $51,300 in 1990. In 1990, Congress increased the maximum wage base for Medicare contributions to $125,000 and in 1993 Congress completely eliminated the maximum wage base for Medicare contributions.

The National Committee last year commissioned a study by Lewin-VHI which concluded that Medicare beneficiaries in the upper income quartile (average annual family income of $66,000 in 1992) will pay on average $159,000 more in taxes than they will receive in Medicare Part A and B benefits over a lifetime under current law. Medicare beneficiaries in the third quartile will pay on average $25,000 more than they receive. Beneficiaries in the first two quartiles will receive lifetime subsidies. See Table 1.

Table 1. Future Lifetime Net Medicare Benefits by Income Quartile under Current Law

Income Quartile	Net Medicare Benefits
Quartile 1	$72,773
Quartile 2	$15,462
Quartile 3	-$24,530
Quartile 4	-$158,555

Source: Paul F. Hogan and Matthew Reilly, Lewin-VHI, "Health Care Insurance Tax Subsidies and Medicare Benefits," June 20, 1994, prepared for the National Committee to Preserve Social Security and Medicare, p. 12. Lifetime net Medicare benefits based on a 2 percent discount rate.

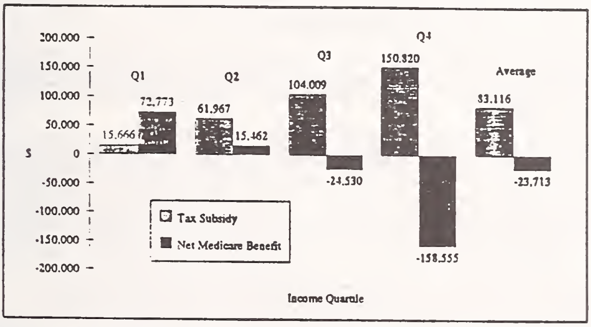
Comparison with Health Insurance Tax Subsidy

It is frequently overlooked that tax free employer provided health benefits are an important government subsidy worth $46 billion in 1995.[1] Approximately 72 percent of families have employer provided health care coverage. These subsidies are more valuable to higher income individuals not only because they have a higher marginal tax rate, but also because they are more likely to have generous employer provided health insurance. Consequently, the average annual tax subsidy for a family with income over $100,000 and employer provided health insurance is $2,261, but it is only $515 for a family with income under $10,000.

Over a working lifetime these subsidies add up for upper income working families. Under current law, lifetime tax subsidies for families in the highest income quartile total $151,000, almost 10 times more than the $16,000 lifetime tax subsidy for families in the lowest income quartile.

While Medicare benefits are progressive, tax subsidies are regressive. Figure 1 compares tax subsidies with Medicare benefits by income quartile. The Medicare Part B premium should not be singled out for means testing, especially when Medicare as a whole is progressive.

Figure 1. Lifetime Tax Subsidies and Net Medicare Benefits by Income Quartile under Current Law



Source: Source: Paul F. Hogan and Matthew Reilly, Lewin-VHI, "Health Care Insurance Tax Subsidies and Medicare Benefits," June 20, 1994, prepared for the National Committee to Preserve Social Security and Medicare, p. 14.

Many Members of Congress would like to make health insurance premiums 100 percent deductible for the self-employed. Based on preliminary data from 1992 tax returns, more than 570,000 tax returns with income over $75,000 claimed a 25 percent deduction for health insurance for the self-employed.[2] It would be ironic if the Medicare premium was increased for beneficiaries with $75,000 in income at the same time that the health insurance tax subsidy was increased for equally wealthy non-Medicare beneficiaries.

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[1] "Estimates of Federal Tax Expenditures for Fiscal Years 1995-1999," prepared for the Committee on Ways and Means and Committee on Finance by the staff of the Joint Committee on Taxation, November 9, 1994, p. 17.

[2] Internal Revenue Service, preliminary data.

Undermining Medicare

Higher premiums for upper income seniors encourages seniors with the lowest health costs to disenroll from Medicare Part B. Under a similar proposal in President Clinton's Health Security Act, it was estimated that 500,000 beneficiaries would drop Medicare Part B[3]—most of the 700,000 beneficiaries who would be affected by higher premiums. Higher income seniors have lower health care costs because they are healthier on average than lower income seniors.[4] In 1987, Medicare spending per upper income senior was only 79 percent of what Medicare spent per capita on all seniors.[5] For healthy seniors, it may make economic sense to disenroll if they have to pay a premium three times higher than the standard premium.

The disenrollment of 500,000 seniors may not seem like much, but it could increase premiums for other beneficiaries if most of those who disenroll have lower health costs on average. Higher premiums also alienate higher income beneficiaries who will be less willing politically to support any general revenue contribution to Medicare. High income beneficiaries after all are also taxpayers who have contributed more than others towards the general revenue subsidy.

Higher Part B premiums would certainly be looked upon as an additional tax if collected through the IRS—the only efficient way to do so. However, some of the higher revenue would be offset by the cost of administering the means test. It would also complicate federal income tax returns, which many people already find incomprehensible.

Even if this proposal would affect only a few beneficiaries with income over $75,000 or $100,000, there is no reason it could not be lowered in the future to $50,000 or $25,000, like the tax on Social Security benefits. An income related premium would be no different than the Medicare catastrophic surtax—without the benefits! In 1989, a "super majority" of Republicans helped to repeal the unfair Medicare catastrophic surtax. The negative reaction may not be as bad as the firestorm over the Medicare catastrophic surtax, especially if the income thresholds are initially set high enough. But higher Part B premiums would neutralize the goodwill earned by House Republican proposals to increase the earnings limitation and repeal the 1993 tax increase on Social Security benefits.

Limits to the Medicare Health Insurance Plan

This proposal is budget driven. Savings will be short-lived, however, unless the factors that are driving both public and private sector health care cost increases are controlled. This short-sighted budget policy is also bad health policy if it reduces Medicare coverage.

Seniors are thankful for Medicare health insurance, but no one should exaggerate its generosity. For full Medicare coverage, including Part B, Medicare beneficiaries pay a premium of $46.10 in 1995. Medicare, however, leaves many gaps in coverage. Medicare does not cover out-of-pocket prescription drugs, dental expenses or most preventive care nor does Medicare have a limit on out-of-pocket expenses. These services are all available in the Blue Cross Blue Shield standard option plan for federal employees for which single employees pay $44.05 a month.

Medicare also has a $100 Part B deductible, a $716 deductible for each hospitalization, 20 percent coinsurance for physician and outpatient services and other co-pays for nursing home care and extended hospital care. A Medicare beneficiary with at least one hospitalization—approximately one out of five beneficiaries each year—could easily incur out-of-pocket costs of $1,000 or more just for Medicare covered services. The bottom line is that today Medicare pays less than half of seniors' health care costs including long-term care. Out-of-pocket health care costs are a larger percentage of income now than when Medicare first started.

As a result more than 70 percent of Medicare beneficiaries have supplemental coverage purchased separately or provided by a former employer. Individuals can pay $40 a month or more just for Medigap coverage. For example, in Ohio in 1995 the average premium for the least comprehensive Medigap plan is $40 a month at age 65—it is almost four times that for the most comprehensive plan.[6] There is no market for supplemental health insurance for any other age group, presumably because there is no need.

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[3] "Documentation of Federal Budget Effects for Health Security Act," p. 16, obtained by the Bureau of National Affairs, December 15, 1993. Some disenrollment would have been due to the higher Part B premium for the new drug benefits.

[4] National Center for Health Statistics, "Current Estimates from the National Health Interview Survey, 1989," Vital and Health Statistics Series 10, No. 176, in the 1994 Green Book, p. 871.

[5] Agency for Health Care Policy and Research: National Medical Expenditure Survey. Upper income was defined as four times the poverty line.

[6] Ohio Department of Insurance

Premiums now cover only 25 percent of Part B costs because Congress protected beneficiaries from health care inflation by limiting premium increases to the Social Security COLA for most of the 1970s. Congress believed that seniors should not be liable for health care inflation over which they have little or no control. Despite recent talk that the CPI overstates inflation, beneficiaries face higher inflationary costs than non-beneficiaries because they spend a greater percentage of their income on health care.

Conclusion

It is understandable for Congress to hold hearings on this controversial proposal in its effort to find savings. However, we hope that our testimony will help guide the Committee away from this path. Congress should be very careful about tinkering with the insurance design of Medicare by means testing Medicare Part B premiums. Means testing the Premium is naturally a tax increase for higher income seniors, which we would expect Republicans to oppose.

Is it fair to charge high income workers more in payroll taxes than they will ever receive in benefits and then charge them three times as much in Part B premium? We strongly believe that it is grossly unfair.

If necessary, the wealthy certainly can take care of themselves. But if support from the wealthy for Medicare erodes, it is the poor and middle class who will suffer.

Appendix I

EXECUTIVE SUMMARY
HEALTH CARE INSURANCE TAX SUBSIDIES AND MEDICARE BENEFITS
Lewin-VHI, Inc.

The National Committee to Preserve Social Security and Medicare asked Lewin-VHI, Inc., to compare health insurance tax subsidies and Medicare benefits in 1993 dollars for one year (cross-sectional) and over a hypothetical lifetime using current law tax and benefits rules (lifecycle). Tax subsidies refer to the savings related to employer provided benefits not being subject to taxation and the tax deductibility of certain health care expenses. The cross-sectional study looks at Medicare Part B benefits net of beneficiary premiums. The lifecycle analysis includes both Part A and B benefits and Medicare payroll taxes.

Medicare and Medicaid are not the only government programs providing health security for Americans.

Approximately 72 percent of families have employer provided coverage. Annual tax breaks for these families are worth $1,516 in 1993 dollars. This is only 20 percent less than the annual general revenue contribution per Medicare Part B beneficiary family of $1,912.

Using a conservative two percent real discount rate, the lifetime tax subsidy under current tax rules for health benefits will average around $83,000 per family in 1993 dollars.

Medicare means testing is both unnecessary and excessive. Medicare taxes and benefits over a lifetime are progressive and recent tax changes have made them more progressive. Negative subsidies to upper income beneficiaries will more than pay for positive subsidies to lower income Medicare beneficiaries. The well-off will begin to object to paying Medicare taxes if Medicare is also means tested.

Using current law tax and benefit rules, the upper income half of Medicare beneficiaries will pay more in taxes over their lifetime than they will receive in benefits and the lower income half of Medicare beneficiaries will receive more in benefits than they will pay in taxes. While benefits are the same for all Medicare beneficiaries, taxes are a percentage of earnings. Since 1994, there is no limit on the amount of earnings that can be taxed.

Beneficiaries in the first income quartile will receive a net subsidy around $73,000 and those in the next quartile will receive a net subsidy around $15,000. In contrast, beneficiaries in the third income quartile will pay around $25,000 more in taxes than they will receive in benefits and the upper income quartile will pay around $159,000 more.

Tax subsidies provide greater benefits to the upper income than to lower income.

Unlike Medicare benefits, tax subsidies benefit the upper income more than the lower income. Those in the upper income quartile receive around $151,000 in tax subsidies over a lifetime, around ten times more than the $16,000 tax subsidy for those in the lowest income quartile. Those in the second income quartile receive an average tax subsidy of $62,000 and those in the third income quartile receive $104,000.

For working families with employer coverage and income over $75,000, the annual tax break is worth more than $2,000 a year, four times the value of the subsidy for working families with employer coverage and income under $20,000. Those familieswith no employer coverage only receive a $56 annual tax subsidy.

The annual tax subsidy for upper income working families exceeds the annual Medicare subsidy. The average annual Medicare subsidy is $1,912. The annual tax subsidy for families with employer coverage and income over $75,000 is $2,119 or more.

If Medicare benefits and tax subsidies are combined, families in the first three quartiles receive approximately the same net lifetime subsidy while families in the upper income quartile almost break even.

Families in the first three quartiles will receive a net lifetime subsidy from both the tax subsidy and Medicare benefits of approximately $80,000 under current law. Families in the upper income quartile will pay about $8,000 more in Medicare taxes than they will receive in tax subsidies and Medicare benefits.

Prepared by the National Committee to Preserve Social Security and Medicare
Research and Policy Development
February 7, 1995

Chairman THOMAS. Thank you. I thank the panel.

Mr. McCrery.

Mr. MCCRERY. I thank all of you for coming today and sharing with us your thoughts on this subject.

I am going to ask a couple of specific questions to Ms. Dixon and Mr. Richtman. While I am asking, I would like for Ms. Phillips and Mr. Hopkins to be thinking about anything they would like to say in response to the testimony of Mr. Richtman and Ms. Dixon.

First of all, Ms. Dixon, I appreciate your telling us that we are doing just fine in repealing the tax increase in Social Security recipients that was put into effect last year, and then saying that, if we are going to do that, then it does not make sense for us to raise or income relate part B premiums.

I think there is a distinction there between the two. I am for repealing the tax increase on Social Security. I did not vote for the tax increase last year and thought it was a bad idea. But Social Security is something, as you know, that seniors have paid into, have been expecting and have worked into their retirement plans. And for us to impose upon them a very high marginal tax rate, which is what we do, in effect, when we take away Social Security benefits, I think is unfair.

However, income relating Medicare part B, when we know that general revenues are subsidizing 75 percent of the true value of that product or that benefit, is entirely different. So I do not think we are inconsistent by supporting a repeal of the tax increase on Social Security benefits and at the same time suggesting that we income relate to some extent part B premiums.

Also, since you brought it up, the catastrophic health care plan of a few years ago, if I am not mistaken, AARP was in favor of that plan. Is that correct?

Ms. DIXON. Yes, our members felt that they were going to receive certain benefits that they needed very badly, prescription drugs and long-term care. Therefore, we supported it, because our members wanted those benefits. Unfortunately, we did not achieve them.

Mr. MCCRERY. Did you not just 1 year later change your position?

Ms. DIXON. No, we did not change our position.

Mr. MCCRERY. Is not the AARP for repeal 1 year later?

Ms. DIXON. No, it went down, because our members learned that they would have to bear the burden of the financing. AARP never went along with the financing mechanism. We were looking for benefits for our members, but this was the best that we could get, so we went along with it.

However, the financing was never something that we agreed to. And when our members learned that the seniors would have to bear the cost of this plan, that was when they did not want to go along with it.

Mr. MCCRERY. I remember that very well. In fact, I voted against it the first time, so I was against you one year and then I was with you the next year.

The fact is that a lot of seniors, your members, at least in my district, did not really want that program to begin with, because they had options in the private sector that were just as attractive to them, and in some cases they could get those at less cost than what we were going to impose upon them from the public sector. So I am not surprised that the program was repealed.

Perhaps that is the model we should look at, as more options in the private sector for seniors, instead of creating more and more programs at the Federal level and impose those on seniors.

Ms. DIXON. Well, we definitely believe there should be systemwide cost containment, not just on the Medicare side, not just on the public side, but on the public and the private side. Otherwise, it will always be just cost shifting.

Regarding our members, we have a membership of over 33 million people, and it is very difficult to get complete consensus among 33 million people, so we have to——

Mr. MCCRERY. I suspect you learned a lot from that experience.

Mr. Richtman, I just want to say that I agree with you about the subsidization of private sector insurance. Some of us on this panel would like very much to do something about that and income relate to some extent the subsidy of private health insurance, as well, through some sort of cap on that. But that is another question. I appreciate your bringing that up, and I think you are right.

Ms. Phillips, would you or Mr. Hopkins, like to respond to anything that we have said or that you have heard?

Ms. PHILLIPS. I would like to point out that CBO did a study last September of entitlements and ways to income relate entitlements. They looked at three different approaches. In that volume were some terrific tables showing who gets entitlement benefits and what income levels they are at. They showed that 20 percent of the families with incomes above $150,000 are getting Medicare. I would think that you would be able to do something about income relating benefits for this group of people.

The Concord Coalition has many members who are also AARP members. In fact, our chapter in the State of Connecticut has been supported strongly by people who are endorsing their Social Security checks over to the Concord Coalition to pay for running a State Concord office.

So there are people out there who are very concerned about the way these programs are spending money and who are willing to put their money where their mouth is. They really believe they can be part of the solution. Lower income people who are struggling with two workers in a family or just one parent, children in child care, much less income, and yet paying the taxes that support these other programs, they do not understand why well-off people who are not working and have discretionary income that they can send to outfits like the Concord Coalition should get a free ride.

Mr. MCCRERY. Mr. Hopkins.

Mr. HOPKINS. The health insurance trust fund will go broke, unless we begin making reforms right now, and certainly A and B should be looked at as a whole when we are making the changes. By failing to make changes now, we are becoming part of the problem. Yes, we should not be afraid to make the bold moves now.

It was suggested that out-of-pocket expenses are more expensive today after 30 years of a government-run program. So when we look at our changes, we have got to take into consideration that the government is not the answer to all our problems.

Mr. RICHTMAN. Congressman McCrery, just to complete one of your questions, the National Committee to Preserve Social Security and Medicare opposed the catastrophic health care plan when it passed Congress, and led the fight to repeal it.

Mr. MCCRERY. I remember that.

Mr. RICHTMAN. So we were on the same side with you both times you voted on that.

Mr. MCCRERY. Too bad you were not on my side in the election, but that is another matter.

Mr. RICHTMAN. As for repealing the tax on benefits and the distinction you are drawing, the fact still remains that, even if you use the figures that the Chief of Staff of the Joint Tax Committee was talking about, you are going to, in effect, take about $8 billion from the same people that you are going to give $15 billion to by repealing the tax. So you are talking about money that the same people are going to be paying the government and getting from the government, and we just want to raise that issue.

Finally, if the Concord Coalition is able to get Social Security recipients to endorse their checks right over to them, I want to compliment them on their direct mail.

Ms. PHILLIPS. This was not done through direct mail. This was done through citizens organizing in their communities, and it came as an absolute surprise to us when we opened the letters and found their checks.

Chairman THOMAS. The gentleman's time has expired.

Mr. MCCRERY. Thank you, Mr. Chairman.

There are some folks in my district who refuse to accept their Medicare benefits or Social Security benefits, because they are fairly well off, they have high incomes and they do not frankly see the point.

Chairman THOMAS. I have had people tell me that this was their mad dress money, and it is nice to know that some folks have found a better and higher use for that money.

Mr. Richtman, I do not think I am confused and I do not think you are confused, but someone, in listening to your testimony, may have been confused, so let us see if we can clear it up. You do not mean to suggest by your testimony that Medicare part B is an insurance program, is that correct?

Mr. RICHTMAN. What I was trying to point out is that I think making a distinction between part A and part B is to some extent an artificial distinction, because——

Chairman THOMAS. When one is mandatory and the other one is voluntary?

Mr. RICHTMAN. Because people consider it their Medicare, people that have Medicare do not usually make that distinction. They understand that part B is optional, they can pay for it or they cannot pay for it. What I am talking about is looking at it in the context of the kinds of benefits people receive as opposed to what they pay through general taxes when they are in the work force and through their premiums and through the HI tax.

Chairman THOMAS. Let me go back to my original statement. You did not mean to create the impression that part B is an insurance program, did you?

Mr. RICHTMAN. Not by itself.

Chairman THOMAS. And you mentioned twice now the cap on fringe benefits. In 1983, I voted to cap fringe benefits and we lost it on this committee by two votes. By using that in reference to suggested policy in other areas, does that mean that your organization supports capping of fringe benefit deductions?

Mr. RICHTMAN. Our organization supports treating these essential tax subsidies fairly, treating people fairly, whether they are in the work force or they are retirees. To means test Medicare beneficiaries and not means test people that are getting these benefits by virtue of the Tax Code is not fair. It should be done fairly.

Chairman THOMAS. Does that mean if we go ahead and means test on Medicare part B, which is a general fund subsidy, you would support capping the fringe benefit deductions?

Mr. RICHTMAN. Frankly, I do not think so, because I think that the——

Chairman THOMAS. So you would not support that?

Mr. RICHTMAN. That is right. I do not think we would.

Chairman THOMAS. You use it as an example, but then you would not support it if it was policy?

Mr. RICHTMAN. No. What I am saying is that the current policy I think is a good one. The way health care policy is structured brings more health care benefits to more people. But by making a distinction here and trying to focus just on the Medicare beneficiaries and means testing their benefits to raise revenue that way we think is unfair.

Chairman THOMAS. But you would not support capping fringe benefit deductions?

Mr. RICHTMAN. I cannot decide that by myself.

Chairman THOMAS. That is a sufficient answer. I just wanted to find out.

Ms. Dixon.

Ms. DIXON. Our organization feels that if higher income Medicare beneficiaries have to pay a higher premium, then working people who have higher incomes should also pay a higher premium. When their employers receive tax breaks, therefore, they are subsidized, also. So we just feel that it should be equitable across the board.

Chairman THOMAS. Ms. Dixon, thank you for that refreshing position which is consistent. I understand you do not have to be consistent, but I appreciate the consistency.

Let me try another one on you. You are concerned that this might produce a cost shift. If the original Medicare part B program was a 50/50 relationship between general fund subsidies and recipient payments, and it is now a 75/25 program, did it not result in a cost shift when it went from 50/50 to 75/25?

Ms. DIXON. In our written testimony, we point out the fact that the 50/50 was changed because the costs of medical care were rising so rapidly——

Chairman THOMAS. But that is a cost shift, is it not?

Ms. DIXON. May I finish?

Chairman THOMAS. Surely.

Ms. DIXON. The Congress felt that the 50/50 would put too much of a burden on too many persons who were unable to bear those costs, therefore, it was changed.

What I was referring to by cost shifting was that the cost would shift from Medicare over to the private sector and, therefore, it would do nothing to reduce overall costs and therefore bring down the deficit. Whenever Medicare benefits are reduced or whatever, then the private sector has to pick that up. Employers will probably have to raise premiums for their employees. Perhaps even some would go out of business. So we still do not have any positive effect as far as the deficit is concerned.

Chairman THOMAS. But do you know now that Medicare is lagging behind the private sector, and that in fact there have been so many changes made in the private sector in controlling the costs of health care, that there probably would not be that classic shift that you are talking about. And one of the reasons that we are talking about making changes in Medicare is because Medicare is now a cost driver.

It used to be that there was a cost shift from the private sector to Medicare, and now Medicare is in fact keeping alive a system that has been changed in the private sector. So we may need to refocus in terms of the way we view the relationship between Medicare and "cost shifts" onto the private sector.

Your argument is that it was just too much money for people to pay which led Congress to go from a 50/50 split to a 75/25 split. Would it not then also make sense that if people had sufficient wealth to be able to pay a greater portion of that shift, 75/25, that we should encourage people who could pay to pay?

Ms. DIXON. Now, when it went from 50/50 to 75/25, that was to accommodate those millions of people of low income.

Chairman THOMAS. But what about the millions of people of high income?

Ms. DIXON. I do not know if there are as many millions as there are of low income.

Chairman THOMAS. How about thousands?

Ms. DIXON. What we are saying is there has to be systemwide reform, rather than focusing on a small population.

Chairman THOMAS. I think you heard the testimony today that all of us are committed to systemwide reform. As part of a systemwide reform, would you accept some kind of an adjustment in the general fund contribution that many nonelderly taxpayers now make to our seniors who have income sufficient to pay their own cost?

Ms. DIXON. AARP would be willing to look at incremental reform, if certain safeguards were in place. One is, as we mentioned, systemwide cost containment. Another would be that the senior population would receive important benefits which they do not now have, such as long-term care and prescription drugs, and there was equity in that the persons who are employed and have high incomes would also be subject to this increased premium.

Chairman THOMAS. You know that in the Contract With America we have already held hearings and are moving forward with legislative changes that would allow long-term care insurance to be deducted from your income tax, and that it would make it available for employers to offer without taxes.

Ms. DIXON. That is something our members want very much.

Chairman THOMAS. In addition to that, we are trying to reform the system under a concept that you heard referred to more frequently now as Medicheck, in which, rather than government offering to pay a prescription program, seniors could take the amount that they now have under Medicare and go out in the private sector and look at the offerings that would include prescription coverage and many other benefits as indicated by your magazine and the insurance packages that you offer, which people could purchase with the dollar equivalent of the current Medicare structure. Would that be something that your organization would be interested in supporting?

Ms. DIXON. It is something that we certainly would have to explore. As I have listened to the testimony today, I am just impressed by the complexity of this issue and we certainly commend the committee for inviting opposing opinions. You have a formidable job to try to bring all of these things together, and we are certainly willing to work with you to try to come to a solution that will be amicable and in the best interest of our country.

Chairman THOMAS. We appreciate it, because we know the system has to be reformed. We would much rather do it with you than without you. But we believe that, in a commitment to all seniors, we are going to do it.

I want to thank the entire panel, including Ms. Phillips, for taking her time to come and testify in front of the group. We look forward to seeing you on future panels, as we begin to look at other aspects of change in this program.

Thank you very much.

The subcommittee is adjourned.

[Whereupon, at 4:33 p.m., the hearing was adjourned to reconvene on Friday, February 10, 1995 at 10 a.m.]

MEDICARE REFORM AND INNOVATION

FRIDAY, FEBRUARY 10, 1995

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:06 a.m., in room B–318, Rayburn House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

Chairman Thomas. I will apologize in advance: The powerful House Ways and Means Committee has relatively few hearing rooms, and when the main hearing room is not available, unfortunately this is our second largest room. In the spirit of the new majority, we are indicating that if anyone wants to stay longer than 10 minutes there is a fee for the seat. It will be applied to the deficit.

Today is the third hearing in the week-long examination of Medicare policy, and this will be a hearing on Medicare reform and innovation.

Any members who have written statements in their entirety, they will be placed in the record. We have discussed throughout this week the Medicare program, the fact that it needs fixing, and not just in terms of particular details. The program really has to be transformed from the midsixties model into one that clearly utilizes the changes that we have seen in the private sector to get ready for the rest of the nineties and especially the 21st century.

The transformation we hope will be along the lines of improving the program for beneficiaries who will gain greater access to higher quality and more cost effective medical care; but second, obviously we need to rein in the growth of Medicare costs which clearly threaten the future of the Medicare program. Based upon the most recent data and the changes in the private sector, this is a growing problem for Medicare in relation to the private sector.

We have got to talk about the use of managed care and a smoother transition into managed care for the Medicare beneficiaries. As we learned earlier this week, there is growing consensus that the Medicare system is flawed and anyone who wants to try to hang on to it is really not doing a service to either the taxpayer or the Medicare beneficiary.

Our subcommittee has undertaken the task of defining the terms of this transformation. The best place to begin is with the positive experience Medicare beneficiaries are having with managed care.

We should look for guidance from the health care revolution taking place in the private sector. We need to look to the private sector to learn ways to adapt its models to the framework of Medicare. If grafting is not possible, then we need to talk about more fundamental reform. Today the testimony will provide insights on managed care in Medicare and the private sector.

Among the witnesses we can especially look forward to is not only our colleague Mr. Pomeroy, who has been with us throughout this discussion, but two former administrators of the Health Care Finance Administration, Bill Roper and Leonard Schaeffer, who are now in the private sector and are at the cutting edge of companies who are in managed care alternatives.

We need to receive guidance on how to improve the design for payment of managed care organizations by Medicare. All of us know that in 2001 the part A trust fund is planning to go broke. When you look at the ways in which you can adjust it—increasing the tax rate, reducing benefits—the shifts in those areas become so enormous that it really is not an option; tripling the tax rate, cutting by two-thirds the benefits, for example, if we are going to continue to play the old game to try to buy time beyond 2001.

Obviously these problems represent a challenge not only to Congress, but ultimately to the American people. It is not going to be easy, but as we heard on Tuesday from Senators Kerrey and Gregg, especially Senator Kerrey, from the Kerrey-Danforth Commission, if we do not begin the task of transforming Medicare, we are going to pay a much higher price down the line for that failure.

I would yield to my friend from Maryland for any statement he may wish to make.

Mr. CARDIN. Thank you, Mr. Chairman.

I would ask unanimous consent that the opening statement by Mr. Stark, the ranking member, be made a part of the record, and that my opening statement in full be made a part of the record.

Chairman THOMAS. Without objection.

[The prepared statement follows:]

Opening Statement
The Honorable Pete Stark

Hearing on Medicare Reform and Innovation
February 10, 1995

Mr. Chairman,

I am pleased that you have scheduled this hearing on "Medicare reform and innovation." I hope that this hearing gives credit where credit is due. Speaker Gingrich has characterized Medicare as a "large, clunky, bureaucratic" system. I'll accept the label of Medicare being "large" -- and with some pride -- although a more accurate term to use is universal, as in universal coverage. Medicare covers 99.1 % of Americans who are over the age of 65, and does so without consideration to where they live, how sick they are, or how much money they have.

As to being bureaucratic and clunky, that might have been true with the Medicare program of the 1960's, but it isn't the Medicare of today. Over the past twenty years, Medicare has led the way in innovations in administration, cost containment, and reforms of the financing system.

As we all know Medicare's DRG-based hospital prospective payment system led the way in reforming the way hospitals get paid. Similarly, Medicare's RB RVS physician payment system has changed forever the way in which doctors are paid. Both are now in wide-spread use across the system -- public and private.

Medicare led the way in developing utilization review through its Professional Review Organizations, review which is now the underpinning of most managed care in the private sector. Moreover, the federal government's involvement in outcomes research and the development of practice guidelines is serving to strengthen utilization review efforts nationwide. And last but not least, Medicare's leadership led to the development of the first uniform billing form for hospitals, the UB-82 in 1982 and its successor, the UB-92. A second form, HCFA-1500, serves as the uniform claim form for physician billing. These are the only claim forms Medicare requires today.

Of course now we hear calls that Medicare's fee-for-service system is antiquated and should be replaced by something called managed care. Medicare also led the way in that area as well. Since legislation passed in 1982, Medicare has been contracting with managed health plans across the country -- 244 such plans at last count. The program has worked well, because choice of managed care in Medicare is voluntary. The plan must provide an attractive enough option so that seniors choose managed care without coercion from anyone.

Medicare's managed care option is not without problems, not the least of which is that seniors who join these plans are generally healthier than the average Medicare beneficiary. Research shows that the cost for beneficiaries joining plans is only about 85% of the average for Medicare. This means that it costs Medicare money, rather than saving money, when seniors join these plans. This problem must be solved before the program can be expanded dramatically. I would note that we passed legislation in 1989 directing the Secretary to improve the payment system, but little progress appears to have been made.

At the same time we are talking about Medicare losing money on every beneficiary that enrolls in an HMO, I read about the tremendous profitability of the managed care industry. If the Chairman would allow me, I'd like to enter in the record a staff review of 15 managed care company financial reports. Roughly twenty percent of every health care dollar in these firms is going for overhead, managers, and profit. This compares to Medicare's overhead of 2% and overhead in the most efficient private HMOs of about 5%. Some HMOs may be giving Medicare beneficiaries their money's worth, but many are not.

It is also possible to point to the kind of reforms we do not want. Recently I received a series of news accounts from the Fort Lauderdale Sun-Sentinel regarding abuse of Medicaid beneficiaries in HMOs and other managed care plans in that State. I'd like to provide to each Member a copy of this series. This report shows that State oversight of Medicaid managed care is abysmal. Because of these findings, Congressman Shaw has stated his intention to call for Congressional hearings as soon as is possible. I support this effort and would like to offer my assistance in holding these hearings.

Medicare is not immune from the problems identified in this Florida Sun-Sentinel series either. In a February, 1994 series by the same paper, Medicare HMOs operating in Florida were found to deny care, provide substandard care, and have unmanageable grievance procedures. I'm glad Mr. Vladeck is here today to discuss these issues that strike at the heart of what Medicare was designed to do -- provide America's seniors access to affordable, high quality medical care.

There is one other issue I'd like to touch upon, Medicare Select. It is my intention to introduce legislation regarding this demonstration program. I have not as yet done so in response to an Administration request. I look forward to the Administration's recommendations today on this demonstration program. A preliminary review of the Medicare Select program has found significant reason for concern and caution -- despite the repeated claims by others that Medicare Select is good because it means more choice for beneficiaries. Of course, what all this vague talk about more choice and reform is really meant to do is disguise an effort to *take away* freedom of choice of doctors and hospitals from the nation's seniors. Let us not be confused that choice of plan is the same thing as choice of physician, because America's seniors know the difference.

Mr. CARDIN. I would like to congratulate you for holding these hearings. I think they are extremely important. We need to look at ways of responsibly reducing the cost of Medicare and looking for innovative ways in which to bring down the growth rate in Medicare expenditures.

I would like to acknowledge one of my teachers who is in the audience. Bill Gradison taught me an awful lot on this committee. It is nice to see Bill back in the committee room.

I would also like to point out, if I might, that one of the ways we can look for innovations in health care reform is to look to our States and giving States more flexibility in dealing with the health care system.

I would just like to point out to the committee the record in my own State of Maryland. Mr. Thomas has heard me mention many times about Maryland's all-payer rate system, and the information has just been made available for the last year, in which it shows once again the State of Maryland has kept hospital costs down at a lower growth rate than the national average. That makes 18 out of the last 19 years Maryland has kept its growth rate below the national average on hospital costs, and we do it with an all-payer rate system.

There is no cost shifting in Maryland. There is no discounting in Maryland. All payers pay the same rate for services at a particular hospital. So if you go to Johns Hopkins Hospital in Baltimore, the hospital does not care whether you are a Medicare patient or whether you are an HMO patient or whether you are a private insured patient or a Medicaid patient; the hospital receives the same reimbursement rate for the services performed by that hospital, as it should, for each person should receive the same high-quality care. We have been able to do that.

Now, there are those who believe that a regulated rate system would discourage managed care. It does not. Maryland has the third highest HMO penetration of any State in the Nation, so we have managed care, and we have an all-payer rate system, but what we have shown is that if you are going to save money in health care costs, you need to do it other than by discounting but by managing the care of the individual and promoting preventive health care.

I hope, Mr. Chairman, we will use Maryland as an example as we look for innovative ways of bringing down the cost of Medicare. Yes, I think we should look to the States, and I think we should look to managed care as a way of bringing down health care costs in Medicare, but I hope that as these hearings evolve our witnesses will tell us how we can bring down the costs of health care by managing the care of the Medicare patient, but not by discounting because you happen to be a bully in the marketplace. I don't think that serves any purpose, and I look forward to the testimony today for helping us in dealing with these very difficult issues.

[The prepared statement follows:]

STATEMENT OF
HON. BENJAMIN L. CARDIN
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

I am concerned at the report that some Medicare Select carriers are achieving savings, and offering lower premiums, based on negotiating discounts of Part A costs, including deductibles, with hospitals. My state of Maryland has almost 20 years of experience with our all-payer hospital payment system. With that system Maryland has taken hospital costs which once ran almost 25% above the national average to 8.1% below that national average over time. Maryland has now outperformed the nation in containing hospital costs in 18 of the last 19 years. Maryland's all-payer hospital system is designed to contain costs, increase efficiencies and spread the costs of uncompensated care equitably across all payers. The results have been impressive: all Marylanders have access to needed hospital services; we have virtually no cost shifting; solvency has been maintained for all efficient hospitals; and our hospitals have retained or enhanced their reputations for clinical and teaching excellence.

The Maryland all-payer system functions on the very premise that all payers - whether public or private, large or small - including Medicare and Medicaid, pay the same prices for the same services. The system is based on principles which have been shown to work: focusing control on costs not profits; establishing attainable and predictable targets; using incentives; minimizing regulatory intrusions on the market; collecting data; focusing on outliers, those providers (and patients) at the cost margins; and taking a long range view.

As we look at reform initiatives it is important to use systems that work not by shifting costs but by actually delivering services more efficiently. The extent to which costs savings in managed care are coming from risk selection and the sentinel effect accomplished by limiting provider panels and requiring massive regulation of medical practice is not a positive development; rather if we are to encourage Medicare beneficiaries to move into managed care, we must encourage those managed care systems to achieve efficiencies and savings by concentrating on their real principles: emphasizing preventive services and managing/coordinating care.

Mr. Chairman, I look forward to a frank discussion of the challenges facing us as we look to improve Medicare services for all of its beneficiaries.

Chairman THOMAS. I thank the gentleman.

As was indicated, anyone who has a written statement that would like to put it in the record, without objection.

Earl, nice to have you back with us again, Hon. Earl Pomeroy from North Dakota, who has had some practical experience at the State level, which is always a danger if you have some knowledge in the area in terms of legislating.

It is nice to have you again. Proceed in any way you see fit.

STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. POMEROY. Mr. Chairman, thank you very much.

The scope of this hearing goes to a very critical matter. My testimony will go to a very, very small subset of exploring the issues of greater managed care under the Medicare care delivery system.

I speak to H.R. 483, sponsored by Representative Nancy Johnson and myself. This bill would take the Medicare Select experiment and apply it to all 50 States and give it a permanent authorization.

I have had a long interest in senior citizen health insurance, dating back 10 years ago to my days in the North Dakota State legislature. I was a State insurance commissioner for 8 years, and during that time worked aggressively to advance the standards of senior health insurances in North Dakota and through the National Association of Insurance Commissioners. With the NAIC, I chaired the Long Term Care Insurance Committee, the Medicare Supplement Committee, I was president of the association, and chaired the task force that developed the model standards for Medigap coverage presently allowed under OBRA 1990.

The Medicare Select initiative was from the get go a modest little experiment, a baby step down the lane of incremental health reform. Medicare Select allowed insurers to negotiate with hospitals for reduced part A deductible charges and passed the savings on to the insured. Medicare paid the claims in an identical manner to other Medigap policies but stood to benefit from the utilization reduction generated.

Not surprisingly, the primary arrangement presently in place in these Medigap Select plans is a restricted network of providers that pass on the discount and provide little or no additional managed care to obtain additional savings.

On the other hand, for a number of insurers, the provider networks where the discount is offered is the same network they have constructed to provide cost-efficient managed care services to their insured major medical and Medicare Select alike. In these instances, even deeper premium discounts are made available to the insureds because of managed care savings. Of course, Medicare and taxpayers also benefit because the insured has selected a more cost-efficient health care provider.

Frankly, I thought at the time of enactment that subjecting such a modest project to the status of a pilot experiment by allowing it in only 15 States and giving it a relatively short authorization period was oversight overkill. In my opinion, the biggest consequence of these limitations has been to deprive seniors in 35 States from a Medigap insurance option which would have saved them some money while promoting managed care.

Anyway, now we have the initial results, and the following conclusions are supported. Not many consumers have it, but those who do enjoy lower premiums and register high levels of satisfaction.

Medicare has not quantified savings nor have they quantified costs from the program. Insurers, particularly those with established managed care networks, find Medicare Select a useful policy feature to bring Medicare supplement policyholders to their managed care network.

Maybe I am missing something, but it seems to me we ought to preserve a program that at its very worst has been a benign presence in the senior insurance marketplace.

When I was an insurance regulator, I figured the insurance consumers knew a lot more about their unique circumstances than I did, and they wanted options available in the market to choose from. With Medicare Select there is no demonstration that seniors should be precluded by government from having the option of saving a little money while selecting a Medigap policy that involves a restricted provider network and managed care.

In North Dakota's experience, the Medicare Select program has more than 10,000 enrollees who pay premiums priced at 17 percent below what the identical policy would have been in the non-Medicare Select program. To date, there has not been a single complaint generated by this Medicare Select book of business to the North Dakota insurance department. Not one.

The experience today in each of the 15 States tends to show that when it comes to Medicare Select, those who have it like it. Concerns about the program tend to be theoretical or anecdotal. I find the actual experience of those in the program is much more instructive as to its merit than those who purport to speak on behalf of senior citizens but don't have the direct personal experience of having had this coverage.

In my opinion, applying Medicare Select to all 50 States and making it permanent will have several positive effects; the national trends toward managed care rather than traditional fee-for-service reimbursements make it increasingly likely Medicare Select enrollees will benefit from lower premiums and managed care provided through established networks of providers.

As we take this step it is certainly appropriate to consider improvements to enhance the program in order to generate greater savings to policyholders. Discounts on the part B deductible should be permitted similar to the part A deductible discount presently allowed. The adequacy of consumer protections should be evaluated, provided that the extent of the existing protections imposed by State regulators are found to be insufficient.

In this regard, perhaps more should be done to insure that every Medicare Select insured has an opportunity to change to conventional insurance from a Medicare Select option on a one-time basis. Additional protections should retain regulatory responsibility with State insurance regulators, and any additional protections contemplated ought to be appropriate for the essentially indemnity nature that the Medicare Select product represents.

Unfortunately, the 6-month extension allowed by the 103d Congress is not sufficient to thoroughly consider design improvements without placing existing programs at-risk of having the programs authority expire. I hope this Congress will not let perfection be the enemy of the good and have the existing Medicare Select program placed in peril while we cogitate about how we might make it better.

In summary, I believe the results of the Medicare Select program justify its extension and national expansion.

Thank you for your consideration of my testimony.

[The prepared statement follows:]

THE HONORABLE EARL POMEROY
before the
SUBCOMMITTEE ON HEALTH

February 10, 1995

Thank you for allowing me to testify on the issue of Medicare Select.

I have had a long interest in senior citizen insurance coverages dating back to my days in the North Dakota State Legislature in the early 1980's. Ten years ago, I became North Dakota's Insurance Commissioner and during the eight years I served in that position, I worked aggressively in North Dakota and in the National Association of Insurance Commissioners (NAIC) to upgrade the health insurance marketplace for senior citizens.

Within the NAIC, I served at various times as chair of the Medicare Supplement Task Force, the long term care insurance task force, as well as President of the association. When OBRA 1990 created the standards for Medicare supplement coverage and the Medicare Select program, I chaired the task force that developed the model statutes and regulations implemented at the state level pursuant to the legislation. These model laws included designing the spectrum of standardized coverages presently allowed in the medicare supplement market.

The Medicare Select initiative was from the get-go a modest little experiment--a baby step down the lane of incremental health reform.

Medicare Select allowed insurers to negotiate with hospitals for reduced part A deductible charges and pass the savings on to the insured. Medicare paid claims in an identical manner to other medigap policies but stood to benefit from utilization reduction.

Not surprisingly, the primary arrangement presently in place on Medicare Select plans is a restricted network of providers passing on the discount and providing little or no additional managed care to obtain additional savings.

On the other hand, for a number of insurers the provider networks where the discount is offered is the same network they have constructed to provide cost efficient managed care services to their insureds--major medical and Medicare Select alike. In these instances, even deeper premium discounts are made available to insureds because of managed care savings. Of course, Medicare and taxpayers also benefit because the insured has selected a more cost-efficient health care provider.

Frankly, I thought at the time of enactment that subjecting such a modest project to the status of a pilot experiment by allowing it in only 15 states and for a relatively short period of time was oversight overkill. In my opinion, the biggest consequence of these limitations has been to deprive seniors in 35 states from a medigap insurance option which could have saved them some money while promoting managed care.

Anyway, now that we have the initial results, the following conclusions are supported:

- Not many consumers have it but those who do enjoy lower premiums and register high levels of satisfaction.
- Medicare has not quantified savings or costs from the program.
- Insurers -- particularly those with established managed care networks -- find Medicare Select a useful policy feature to bring to their managed care network.

Maybe I'm missing something, but it seems to me we ought to preserve a program that at its very worst has been a benign presence in the senior insurance marketplace.

When I was an insurance regulator, I figured the insurance consumers knew a lot about their unique circumstances and they wanted options available in the market to choose from. With Medicare Select there is no demonstration that seniors should be precluded by government from having the option of saving a little money by selecting a medigap policy that involves a restricted provider network and managed care.

In North Dakota's experience the Medicare Select program has more than 10,000 enrollees who pay premiums priced 17 percent below those insured in conventional medigap coverage. To date, the insurance department has not received a single complaint from a Medicare Select policy holder.

The experience to date in each of the 15 states tends to show that when it comes to Medicare Select, those who have it like it. Concerns about the program tend to be theoretical or anecdotal. I find the actual experience of those in the program to be more instructive about the merit of the Medicare Select program than those who purport to speak on their behalf.

In my opinion, applying Medicare Select to all 50 states and making it permanent will have several positive effects. The national trends toward managed care rather than traditional fee-for-service reimbursement make it increasingly likely Medicare Select enrollees will benefit from lower premiums and managed care provided through established networks of providers.

As we take this step, it is certainly appropriate to consider improvements to enhance the program.

In order to provide greater savings to policyholders, discounts on the part B deductible should be permitted similar to the part A deductible discount presently allowed.

The adequacy of consumer protections should be evaluated, provided that the extent of existing protections are found to be insufficient. In this regard, perhaps more should be done to ensure that every Medicare Select insured has an ongoing opportunity to change to conventional insurance on a one-time basis.

Additional protections should retain regulatory responsibility with state insurance regulators and be appropriate for the indemnity-based nature of the product.

Unfortunately, the six month extension allowed by the 103rd Congress is not sufficient to thoroughly consider design improvements without placing the existing programs at risk of having the program's authority expire. I hope this Congress will not let perfection be the enemy of the good. The consideration of refinements must not jeopardize the Medicare Select program or unnecessarily complicate things for those who have stepped forward to provide this coverage.

In summary, I believe the results of the Medicare Select program justify its extension and national expansion. Thank you for your consideration.

Mr. THOMAS. Thank you very much, Congressman Pomeroy.

Mrs. Johnson, the author of H.R. 483, will inquire

Mrs. JOHNSON. Thank you very much.

It is a pleasure to welcome you, Congressman Pomeroy, my cosponsor of this legislation. It is very rare, frankly, that we consider legislation in this body where a Member has had so much direct experience not only with providing the product but with protecting the consumer to guarantee that the consumer does in fact get the care they believe they are going to get, the quality care they think they are going to get, and the options that they want. And I value your experience out on the frontlines in implementing this program as an insurance commissioner, and in helping me do the research that we did last year, to look and see how it is working and what is happening.

I do want to mention to you that as we have spoken that this is not the end of the road, if we make this permanent and available in all States it doesn't for a moment relieve us of the responsibility, especially in the context of the changes that are ahead of us of integrating this design or considering its structure in the years ahead.

I wanted you to be, if you could, a little bit more specific about the regulations that already govern this program. This is not just something out there without any controls around it. There are both Federal regulations and State regulations. If you could point out some of the ones that you think are most important to it, I think it would be helpful to the committee in its considerations.

Mr. POMEROY. Well, the OBRA 1990 legislation that put this pilot out there in place did make requirements that there be certain protections for the consumers, and before a State would be allowed to offer these products they had to have provisions in place that governed these protections.

First of all, the networks must offer sufficient access. In other words, in the city of Los Angeles you couldn't have just one doctor and hospital signed up if it was not sufficiently accessible by the policyholders it was being marketed to. The networks must have ongoing quality assurance programs so that internal quality is assessed on an ongoing basis. The insurer must provide disclosure at the time of the enrollment that this is a different product, this is a limited, restricted access product, and the disclosure must also provide notice as to provisions for out of area and emergency coverage as well as availability and cost of available Medicare supplement policies that are not Medicare Select policies and don't have these restrictions.

From a starting point, that is a pretty good base, I think, of consumer protections and maybe has something to do with the fact that there haven't been more complaints generated on this new product.

Mrs. JOHNSON. In your experience, what do consumers get for choosing a Medicare Select product?

Mr. POMEROY. Well, in the State of North Dakota, for example, they will access the Blue Cross-Blue Shield provider network.

Now, the Blue Cross-Blue Shield provider network in my State includes most everybody. So access is not restricted particularly effectively. The part A deductible is waived, so the cost of the premium is reduced, but I think in addition to that that managed care devices that Blue Cross-Blue Shield has implemented, which means that Blue Cross is doing more on a given case than simply writing the claims check as has formerly been the case and is still the case with pure indemnity providers of Medigap coverage, means that the care is more cost efficiently provided, that means claims experience is less and that means further savings to the policyholder on their Medigap piece and it means savings to the Federal Government and taxpayers who pay the bulk of a Medicare claim.

Mrs. JOHNSON. Thank you very much, Mr. Pomeroy.

One of the things that I think is being overlooked in this discussion is that managed care does offer to seniors protection against one of the major causes of hospitalization among seniors, which is overmedication.

There is a much greater possibility of your medications being integrated and coordinated in a managed care system, and that has traditionally been a very serious cause of senior hospitalization, so it is a quality issue for seniors as well as a cost issue for us all.

Thank you for your testimony and for your experience.

Mr. POMEROY. Thank you.

I would like to note for the record that we are having this hearing today on a program that was extended because of your efforts. It would have expired without question in my opinion at the end of the calendar year but for a really heroic effort put forth by you at the end of the 103d.

Mrs. JOHNSON. Thank you.

It took a good team. We did manage to save a program that for 400,000 seniors is the difference between more care and less care.

Thank you.

Mr. POMEROY. That is right.

Chairman THOMAS. Would the gentleman like to inquire, the gentleman from Washington.

Mr. MCDERMOTT. Yes, thank you, Mr. Chairman.

Congressman Pomeroy, you are aware that the department is going to follow you and suggest they don't think this is a good program. I am sure you have investigated that, and I would like to hear your answers why you think they are wrong in wanting to get rid of this program.

Mr. POMEROY. Actually, it is my understanding that HCFA will be testifying this morning that this program isn't the greatest thing since sliced bread, that it has had kind of a benign effect out there that it has not saved Medicare money. For the reasons that I indicated in my testimony, I believe they have come to that position. It is not a particularly grand policy change, policy design change. It is a small one.

Moreover, it has only been allowed in 15 States and only for a relatively short period of time, so I don't think we have seen its full fruition. Maybe we see things differently. For me if it generates for those who have it a lower premium and if it provides for those who have it a level of coverage for health care that they find satisfactory in fact that they like it, I am confused about any reason to pull the plug on it.

Now, if HCFA could demonstrate that in fact because of the lower cost of access to care utilization was increased and Medicare was shoveling money out the door for Medicare Select recipients, that they weren't paying for other Medicare insureds, then I would say Medicare—HCFA has a legitimate gripe with this product, and I would be very concerned about actually having something that we mean to decrease costs, increasing costs. That will not be their testimony today, however, so I am kind of confused that the department would find this to be a big deal one way or another.

Mr. MCDERMOTT. Well, have you seen the Research Triangle Institute study? Have you had an opportunity to look at that?

Mr. POMEROY. Yes.

Mr. MCDERMOTT. They say that one-third of all the Medicare Select networks include only hospitals. It is not managed care. Blue Cross in three States, including California, converted their entire pre-OBRA people in Medicare into this Select program so they wouldn't have to standardize their programs.

You understand all those things, and you still think it is a good program to keep in place?

Mr. POMEROY. Well, first of all, let's take a look at the design of the program. You can only waive the part A deductible, small wonder, therefore, that physicians on the part B haven't participated. We haven't allowed them by the design of the program to do it.

Second, Blue Cross-Blue Shield I think will tell you as they testify later, in fact the testimony of a former HCFA director himself, that they did not roll their pre-OBRA population into Medicare Select for the exclusive purpose of avoiding standardization.

In fact, when I chaired the committee that developed the standardized products, the Blue Cross plans, including the California plan was very much represented and participating in that process.

Mr. MCDERMOTT. So you disagree with the study?

Mr. POMEROY. I think that the study is hardly conclusive evidence that this thing is such a blight on the senior insurance market it ought to be pulled.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Any other member wish to inquire?

Earl, let me use you in terms of your technical expertise in your previous life. If you have got a product structured like Medicare Select as a pilot program with a limited life, what would be the normal reaction of a company in terms of talking about gearing up to go into a market like that?

Mr. POMEROY. Well, you would certainly let somebody else spend the research and development money to get it on the market and wait and see what the result was, whether it panned out in market experience and whether Congress let it go forward, and so I believe that the relatively short authorization period has discouraged development, and I might also say that by limiting it to 15 States there are networks that cross State lines, and that would also be disruptive, it would disrupt your normal care delivery network and so that would further discourage other managed care insurers from going into this product.

Chairman THOMAS. If someone were to say from your position as an insurance commissioner or even someone who understands the business that maybe we will allow Medicare Select to continue but only for another 6 months, only in the 15 States that we had established it, and you can't really go out and aggressively enroll new folks, what are they trying to tell you where they want the program to go with that kind of a message?

Mr. POMEROY. That isn't a helpful signal to the market. You know what, on the other hand, that extension might be necessary if we are really going to do a good job of figuring out how we can improve this, and before we apply it to the 50 States I don't take exception to the notion that nothing is perfect.

Maybe we can make this better, but what frustrates me is, this didn't just happen. I was a cosponsor of the bill last session, I didn't have a visit with HCFA about this matter until Monday. I mean, where have we been?

We didn't have to get so close to time running out to roll up our sleeves and get serious about trying to improve it. Now I want to improve it if it can be improved. I want even more incentives for managed care if we can put them in here safely.

I am frustrated, frankly, that our options are a short extension versus the prospect of improving it, but, Mr. Chairman, in that context I might go for the short extension if there were likely improvements that would work, if a prima facie case was made that there were improvements that we probably could implement, we just needed a little more time to look at.

Chairman THOMAS. Thank you very much for your testimony. I look forward to your continued participation with us in trying to reshape the program.

Thank you very much.

Our next witness will be Bruce Vladeck, Administrator, Health Care Financing Administration.

As you sit down, I will just tell you that this Chairman and particularly the members on our side of the aisle are anxious for your testimony because earlier this week in full committee we had both the Secretary of the Treasury, Mr. Simon, and the Health and Human Services Secretary, Mrs. Shalala, as we discussed the President's overall budget, and the key points I think that were made in the——

Mr. MCDERMOTT. If the gentleman will yield, the Secretary of the Treasury is not Simon, I think it is Rubin.

Chairman THOMAS. I apologize. Thank you very much.

Mr. MCDERMOTT. That is another administration.

Chairman THOMAS. Coming out of my time warp. I didn't like what he had to say, either.

Mr. MCDERMOTT. I am listening to you.

Chairman THOMAS. Secretary of the Treasury Rubin in presenting the President's budget indicated there were no significant Medicare cuts, and obviously in the previous budget $124 billion had been slated for reduction to be spent in reforming the health care structure, but also there were no programmatic changes either, and so I am looking forward to your testimony because both Secretary Rubin and Secretary Shalala said that the President's commitment is a hand reaching out in partnership to shape these programs, although it isn't on paper there was a clear indication there was a willingness to work together to make changes, and my assumption as an administrator in the very particular area of this administration that you are going to present us with that hand reaching out in terms of this new partnership, and I will listen to your testimony in that light.

The gentleman may proceed in any way he sees fit. Obviously his written statement will be made a part of the record, without objection.

STATEMENT OF HON. BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Vladeck. Thank you very much, Mr. Chairman. I appreciate the opportunity to put the full statement on the record.

I am very pleased to be here today to begin the dialog, Mr. Chairman, to which you just referred about the current state of the Medicare program, and, more importantly, about its future.

More than any Members of this Congress, the members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable populations that we serve, and have contributed over the years to major improvements in the program.

Medicare is a popular and a successful program. I believe we need to work together to build on its successes and to strengthen it for its beneficiaries and for the taxpayers who are its future beneficiaries. Together we can improve and expand choices for Medicare beneficiaries without substantially damaging the program.

We in HCFA have been working very hard to make Medicare an effective, affordable, and customer-friendly program for beneficiaries. At the same time we have been working to implement administrative and program improvements that maximize the efficiency and cost-effectiveness of the program.

While my written testimony includes more details, I want to begin by reviewing some of our recent efforts and successes, and then provide you with an overview of our efforts in the area of managed care.

Finally, I would like to discuss some of our other initiatives to improve the administration of the Medicare program. As the world's largest health insurance program, Medicare is by many measures one of the most successful. It is, as you know, administered through a very special kind of public-private partnership in which direct administration of the program is carried out by private contractors under our supervision.

Last year almost 36 million persons were served by the Medicare program, and over 750 million claims were processed. Payments totaled almost $160 billion. Even so, those payments accounted for slightly less than half of the health care expenses of elderly beneficiaries.

Yet, contrary to recent public discussions, it is important to emphasize who our beneficiaries are and that relatively few of them can be considered financially well off. I call your attention to chart 1, which is on the easel. I don't know how Sandy got all of the audience out of the way to see that. Copies of these charts are in my written statement as well.

As you can see, in 1992 approximately 83 percent of our program spending was on behalf of those with incomes less than $25,000. The elderly population is slightly more affluent than the Medicare beneficiary population, and there is a very strong correlation, an inverse correlation, between the income of beneficiaries and their use of health services that needs to be taken into account as we consider changes in the program.

Currently, if I can refer to the second chart, 20 percent of our beneficiaries are either 85 years old and older or persons with disabilities, including end-stage renal disease. These two subparts of the Medicare beneficiary population are by far the fastest growing parts of the population.

I would submit to you that we have very little evidence on how to optimally take care of the old-old and disabled under any systems of care. One of the major challenges we face going forward in the Medicare program is developing better models to more effectively provide appropriate clinical services to those populations.

I urge you to think about these basic facts as you examine the future of Medicare. Millions of elderly and disabled Americans now have not only health care coverage but a quality of life they would otherwise lack because of Medicare.

Despite the size of the program, we have maintained a very high level of consumer satisfaction while keeping administrative costs at less than 2 percent of Medicare outlays.

In contrast, as you know from all the health care reform discussions last year and the year before, in the small group private insurance market, administrative expenses can run as high as 25 percent and in the most efficient parts of the private large group market they tend to be approximately 5 percent.

One of the reasons we have been able to keep our administrative costs down is because we have the most sophisticated electronic provider communication network of any large insurer in the United States. Ninety percent of our hospital and skilled nursing facility claims are submitted electronically; two-thirds of our physician claims are submitted electronically. As seen in the third chart, we measure up very favorably when compared to private insurers.

We have also focused on reducing the paperwork burden by collaborating with the health care community to develop uniform national claims forms for physicians and for all other facilities. This is now the only claims form that we require from those providers.

Many private insurers use this form but also require significant additional documentation as part of the billing process. During the Clinton administration, the average rate of growth for Medicare has decreased significantly.

As you know, the President's budget for fiscal year 1996 projects a 9-percent annual average rate of growth for the 1996–2000 period. That number is down from the midsession review by more than 1 percent per year.

This decline is largely attributable to decreases in part A expenditures, resulting from decreases in inflation in the economy as a whole, and particularly in hospital cost inflation, as well as a decrease in the case mix complexity of inpatient cases.

As noted by Chairman Thomas, further discussions on reform and innovation in the Medicare program must include discussions of managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options that are available to the privately insured population.

The cornerstone of our policy is informed choice in a fair marketplace where beneficiaries have full and objective information and are not discriminated against on the basis of relative need. Currently 74 percent of Medicare beneficiaries have access to a managed care plan—that is to say, they live in a county in which we have a contract with one or more managed care entities—and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. Eleven counties have 40 percent or more of our beneficiaries enrolled in managed care, and more than 80 counties have Medicare managed care enrollment levels that are 20 percent or higher.

The year 1994 was one of particularly strong growth in Medicare managed care. We experienced double-digit increases both in plan enrollment and in the number of plans participating in the program. More than 50 percent of our new risk contracts are in areas that previously had four or fewer plans, and we now have five States in which we have risk contracts where in previous years we had none, including Connecticut, New Hampshire, Delaware, Alabama, and Louisiana.

The total number of plans with which we contract increased slightly more than 20 percent last year alone. However, as we work to extend and broaden managed care opportunities for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures from overly aggressive efforts in both the Medicare and Medicaid programs.

The movement to managed care cannot outpace the capacity of plans to serve large numbers of new enrollees, especially enrollees with the expensive and special health needs seen in the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way we pay managed care plans.

Currently, the expansion of managed care is costing the Medicare program money rather than achieving savings. Our evaluation suggests that Medicare pays almost 6 percent more for every enrollee in managed care than we would have paid if the beneficiary had stayed in fee-for-service Medicare. This is because managed care tends to attract healthier members of our population whose costs are significantly lower than average.

We are doing a lot of work to improve the payment methodology so that it doesn't deter us from expanding managed care. We have a number of research projects and demonstrations underway to address the situation and we would be glad to describe them to you or your staff in greater detail. We hope by the end of this calendar year to have some significant results.

Again, our position is that the emphasis must be on choice. Medicare beneficiaries themselves should determine the pace of the Medicare movement to managed care. Managed care will succeed only to the extent that plans are able to prove the value of their products to the beneficiaries, and as beneficiaries recognize the benefits of coordination of care and case management that high quality managed care plans do provide.

In addition to our efforts to improve current managed care options under Medicare, we want to make available to beneficiaries a new PPO option, preferred provider organization, similar to what is increasingly the most popular form of plan in general insurance markets and similar to the most popular plan in the Federal employees health benefits program—indeed, the one in which I am personally enrolled.

Under this option, we would like beneficiaries to be able to choose to go to any physician at any time, but with differential cost sharing depending on whether they are in- or out-of-network. In developing a PPO option for Medicare, we think we can learn a lot from our experience with Medicare Select.

As you know, Medicare Select was designed to create a hybrid of managed care and Medigap that would benefit both beneficiaries and Medicare. However, our preliminary evaluation shows that while premiums for beneficiaries have been reduced, Medicare does not share in savings.

The basic problem, as reported in our evaluation, is that Medicare Select plans have limited incentives to manage total costs. Savings from beneficiaries are generally the result of hospital discounting arrangements rather than the act of managing care or the efficiency of particular networks.

As a result, this option does not approve the efficiency of the Medicare program, and beneficiaries do not receive benefits from coordinated care. In fact, if proposals to expand Select discounting to part B services were enacted, Medicare costs, according to our preliminary discussions both with CBO and our own actuaries, would actually increase as physicians increased volume to recoup revenues lost from discounts.

We are also concerned about the adequacy and scope of beneficiary protection standards in the current Select program. We feel very strongly that beneficiaries should not have to worry about the quality or access provisions of any choice they make under the Medicare program, and we look forward to working with you on this issue. We also hope to be able to work with you on developing the PPO option in the months ahead.

In that context, we may wish to consider another extension of the Select demonstration. This would alleviate uncertainty for existing plans as we try to work toward a longer term strategy and allow time to make appropriate changes based on the final evaluation of the demonstration experience, which is expected at the end of this calendar year.

As we work together to extend the managed care options available to Medicare beneficiaries, we need to do a much better job educating beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion that works against choosing managed care. To understand their choices, beneficiaries need to negotiate through differences in benefit packages, cost sharing structures, and premium amounts.

In addition, they are faced with enrollment periods that vary by plans, and in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one-time eligibility for open enrollment in Medigap.

We would like to do everything possible to permit managed care options to compete fairly for beneficiaries in a fair market.

As I mentioned earlier, there has been a lot of concern about the payment methodology for Medicare risk contractors. Very shortly after I became Administrator of HCFA, we invited the industry to propose alternatives to our current methodology. We have no earth shattering results to report from that activity.

One concept that has recently received widespread support and attention from industry, academia, and commercial payers more lately is that of competitive bidding. Proponents of competitive pricing models claim that the approach will result in payments that more accurately reflect the true cost of doing business, in addition to promoting efficiency through greater competition among health plans.

We think this is a promising idea. We have begun exploring it, and we would like to test variants of it as demonstrations in several geographic areas.

However, in order for these demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas, and we would be interested in working with the subcommittee on the structure of such a demonstration.

Managed care options, while of growing importance to the administration of Medicare, are not the whole story. We are also actively working to improve management throughout the program, and to continue to make innovations in the fee-for-service program, which we expect, regardless of the rate of growth of managed care, to be with us for well into the future.

Under the leadership of President Clinton, Vice President Gore, and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million Medicare and Medicaid beneficiaries receive the health care they need when they need it. This means refocusing all our activities around beneficiaries and beneficiary service.

We have undergone significant internal and external change to insure that a customer-first philosophy becomes reality. We are working with our customers to make our publications and notices easier to understand; we are simplifying Medicare claims administrations so the claims determination will be more consistent from one part of the country to another; and we are measuring and improving customer satisfaction on a regular basis through the use of surveys, focus groups, and meetings.

At the same time, we have been working very closely with the Inspector General's Office in the Department of Health and Human Services, and with the Department of Justice, to redouble our efforts to deter, detect and pursue fraud and abuse against the Medicare program, which, given the particular vulnerability of our beneficiaries, has effects not only on our outlays but also on the health of the people we serve.

We are also looking very hard at integrating delivery systems beyond the parameters normally found in existing managed care arrangements. In particular, we are looking at all the long-term care services provided through both Medicare and Medicaid to find ways that they can be better coordinated with one another and with the acute care system. In particular, we are focusing on the home health care programs, which, as you know, have been growing with particular rapidity in recent years.

In conclusion, for 30 years Medicare has been insuring the Nation's elderly and disabled. We know from our focus groups, and I think you all know from your interactions with your constituents, that beneficiaries feel a certain ownership of the program. That feeling is justified. Through their payroll contributions and those of their employers during their working lives and through their own premium payments, beneficiaries contribute roughly 70 percent of their insurance costs.

We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We do look forward to working with the subcommittee to improve and expand choices available to beneficiaries while protecting quality, access, and value.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF BRUCE VLADECK
HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee

I am pleased to be here today to begin a dialogue with this Subcommittee about the current state of the Medicare program and, more importantly, about its future. More than any other members of this Congress, the members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable population that we serve, and have contributed to major improvements in the program over the years. Medicare is a popular and successful program. I believe we need to work together to improve on the program's success and strengthen it for its beneficiaries and the taxpayers who support it.

We in HCFA have been working very hard to make the Medicare program an effective, affordable and "customer friendly" program for beneficiaries. At the same time, we have been working to implement administrative and program improvements which maximize the efficiency and cost effectiveness of the program. I want to begin by reviewing some of our recent efforts and successes and then provide you with an overview of our efforts in the area of managed care. Finally, I would like to discuss some of our initiatives to improve the administration of the Medicare program.

I. SUCCESSES

Medicare is the world's largest health insurance program and by many measures one of the most successful. It began in 1966 as a Federal health insurance program for the elderly and was expanded in 1972 to cover disabled persons and those with End Stage Renal Disease (ESRD). The Medicare program was established because our vulnerable populations had difficulty obtaining private health insurance coverage.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under Parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment.

Today, we maintain Medicare's commitment to serve the most vulnerable. Medicare is the largest payor of the elderly's health care expenses. As the Subcommittee examines the future of the Medicare program, I would urge you to consider the following important facts about Medicare beneficiaries.

o Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000. (CHART 1)

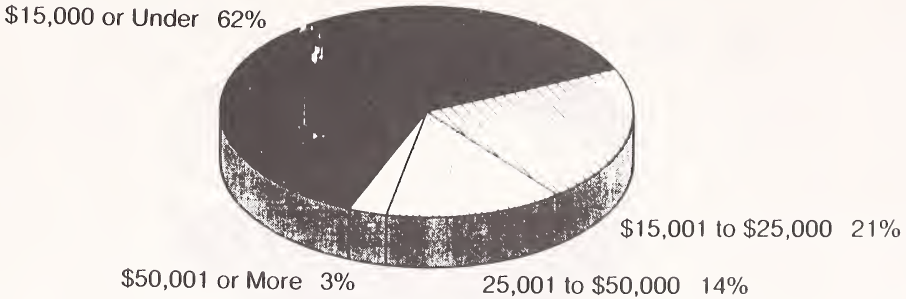
o Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities including End Stage Renal Disease (CHART 2).

o Third, per capita health care spending for aged beneficiaries is 4 times the average for the under 65 population.

Medicare is successfully fulfilling its mission and beneficiaries continue to express a high degree of satisfaction with the program. Millions of elderly and disabled Americans now have health care coverage and a quality of life that they would otherwise lack, thanks to the Medicare program.

Share of Program Expenditures by Income

Of Medicare Individuals or Couples, 1992



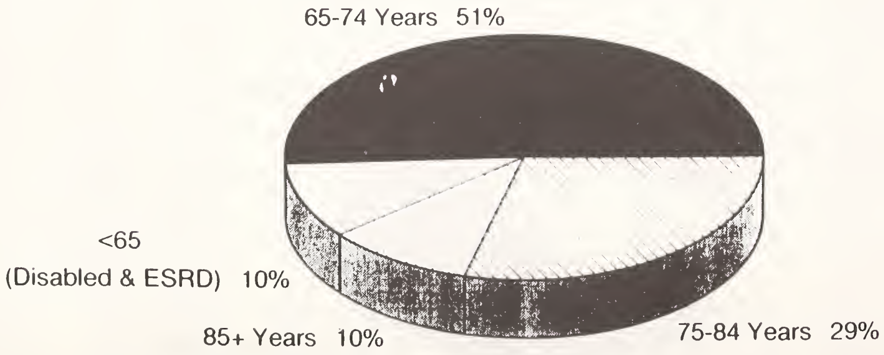
83% of Expenditures: Annual
Income of $25,000 or Less

Excludes 2.2% not reporting income.
Also Excludes HMO enrollees (9%).
Source: HCFA/OACT

Chart 1

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



Total Beneficiaries=35.6 Million

Source: HCFA/BDMS

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Chart 2

Innovative Program Administration

Despite the size of the Medicare program, we have maintained a high level of consumer satisfaction with low administrative costs, less than two percent of program outlays. In contrast, private insurance administrative expenses are about 25 percent in the small group market and about five percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: Ninety percent of Medicare's hospital and skilled nursing facility claims and 67 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. (CHART 3)

We have focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

Decline in the Medicare Baseline

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's FY 96 Budget, the projected annual average rate of growth for 1996 - 2000 is 9.1 percent. In contrast, six months ago in the Mid-Session Review, the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

II. MANAGED CARE AND THE MEDICARE PROGRAM

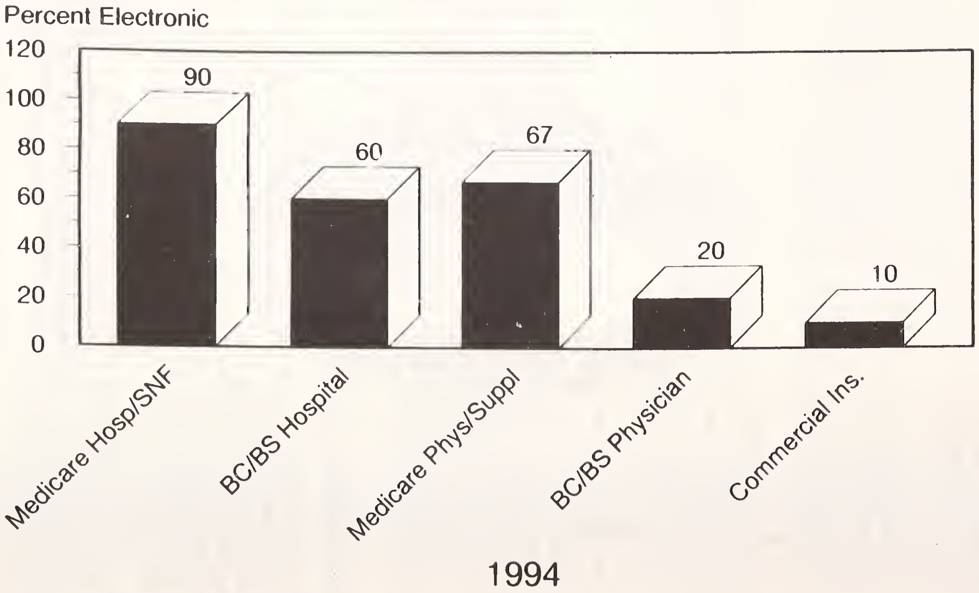
Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

Electronic Submission of Claims

Medicare vs. Private Insurance



Source: HCFA/BPO; Blue Cross Assoc.

P78 HCFACHT2

Chart 3

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population whose health care costs are lower. Efforts are underway to improve the current payment methodology so it doesn't act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

New Managed Care Options

In addition to our efforts to improve current managed care options under Medicare, we want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, our objective would be to allow beneficiaries to choose to go to any physician at any time, subject to higher cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. As you know, Medicare SELECT was designed to create a hybrid of managed care and Medigap that it was hoped would be beneficial both to beneficiaries and to Medicare. However, our experience under the demonstration has been that while premiums for traditional Medigap benefits are reduced, Medicare does not share in the savings.

The reason for this apparent anomaly is that the lower Medigap premiums in Medicare SELECT plans are generally the result of hospital discounting arrangements rather than the active management of care or the efficiency of the SELECT networks. The basic problem with Medicare SELECT is that there are limited incentives for plans to manage the total costs. As a result, Medicare does not participate in any savings, and beneficiaries do not receive the benefits of coordinated care that they would receive in efficient networks. In fact, if proposals to expand SELECT discounting to Part B services are enacted, Medicare costs would actually increase, as physicians increase utilization to recoup their discounts.

A second issue with Medicare SELECT deals with the adequacy of beneficiary protection. We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices. We look forward to working with the Subcommittee on this important issue.

We also hope to be able to work with the Subcommittee on the PPO option in the months ahead. In addition, given the impending deadline for expiration of the SELECT authority and the need to examine the demonstration experience before the program is expanded to all states, Congress may wish to consider a 6 month extension of the demonstration for existing plans. This would alleviate the uncertainty for existing plans, and provide time to make appropriate changes to SELECT based on demonstration experience.

Beneficiary Education

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

Quality and Managed Care

Today, managed care organizations providing services to Medicare and Medicaid beneficiaries are required to have internal quality assessment and improvement programs to identify ways to improve the delivery of health care services and the health care itself. We also require independent external review of quality of care delivered to our beneficiaries.

HCFA is working in collaboration with the industry on a long term effort of developing a single set of measures that could be used by all payors to address the full range of a health plan's membership and performance.

The first phase of this effort centers on major performance measurement projects underway in both Medicare and Medicaid. These are designed to help us develop measures that are focused on the special needs of our diverse populations.

In Medicaid, we are working collaboratively with National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool HEDIS (Health Plan Employer Data and Information Set) to the needs of the Medicaid program.

We chose HEDIS as the template for our Medicaid effort for several reasons:

- HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid. Some states are already adopting HEDIS. We feel it is important to provide some national leadership.
- We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMOs developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an elderly and disabled population, for example, in management of chronic conditions. These measures will them be considered in conjunction with the broader HEDIS effort.

Payment/Competitive Bidding

As I discussed above, concerns about the payment methodology for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. Early on, when I became Administrator of HCFA, I invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the Subcommittee on the structure of a competitive bidding demonstration.

III. IMPROVED PROGRAM MANAGEMENT

Managed care options while of growing importance to the administration of the Medicare program are not the whole story. We are actively working to improve management throughout the program and to make continued innovations in the fee-for-service program.

Customer Service Initiatives

Under the leadership of President Clinton, Vice President Gore and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million beneficiaries (Medicare and Medicaid) receive the health care they need when they need it. This means that beneficiaries come first in all that we do. HCFA has undergone significant internal and external changes to insure that the "customer first" philosophy becomes a reality. Throughout the agency, we are working to improve communications with beneficiaries -- whether it be one-on-one in person, on-line through the computer, over the telephone, through our numerous publications or through the media.

The nature of the Medicare program is such that there are numerous other people and organizations that have closer contact with beneficiaries than HCFA. They are also our customers and our partners in providing health care services - providers such as hospitals, nursing homes, home health agencies, physicians and medical suppliers; contractors (carriers and intermediaries) that process and pay Medicare claims; and, Peer Review Organizations that assure the quality of health care services.

We have developed a set of customer service standards that apply to our interactions with beneficiaries and our partners. These standards apply to all of our communications, claims processing activities, customer satisfaction, consumer choice, health care quality and program administration. For example, we are working with our customers to make our publications and notices easier to understand. We are simplifying Medicare claims administration so that claims determinations will be more consistent. We are placing a premium on measuring and improving customer satisfaction through the use of surveys, focus groups and meetings.

We also believe that the need for integrating delivery systems will become more and more critical as our population becomes increasingly diverse and older with more chronic care needs. In order to meet these needs, it is clear that HCFA must maintain a collaborative relationship with its partners in the provider community and assist them to improve their focus on customer service. Several such initiatives are already underway. HCFA is examining all of the long-term care services provided by both Medicare and Medicaid and is considering ways that these services can be better coordinated with one another and with the acute care system. A similar review of home health care programs has also been undertaken.

Fraud and Abuse

Starting at the Office of the Administrator and at every level of HCFA, we have expanded and strengthened our efforts to root out fraud and abuse against Medicare and Medicaid and to vigorously pursue those who commit such illegal activities. We operate in a partnership, not only with the Department's Office of the Inspector General, but with the Department of Justice, including the FBI, state and local law enforcement agencies, and our contractors. Further, HCFA is increasingly exercising its authority to suspend payments to providers and suppliers when evidence of fraud exists.

In addition, HCFA is reviewing and changing programs and policies that have been found most vulnerable to abuse. For example, in order to better monitor fraud and abuse related to durable medical equipment (DME), HCFA has changed the procedures for claims processing. Four carriers are now responsible for DME claims processing rather than the previous 33 carriers, a system which provided DME suppliers opportunities to submit claims to the carrier whose payment policy was most liberal. The new system of using four regional carriers reduces the chance for fraudulent billing because suppliers must submit claims to the carrier in the region where the beneficiary resides.

The use of more sophisticated data processing systems, such as the MTS system, that I discussed earlier, further increases the chances of detecting aberrant patterns that might indicate abusive behavior. The MTS system will greatly improve HCFA's ability to screen Medicare claims for errors and fraud.

IV. CONCLUSION

For thirty years, Medicare has been insuring the nation's elderly and disabled. We know from our focus groups, and I think you are all aware from interactions with your constituents, that beneficiaries feel a certain ownership of the program. This feeling is justified. Through their payroll contributions and those of their employers, during their working lives, and through their own premium payments, beneficiaries in fact contribute 70 percent of their insurance costs. We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We look forward to working with this Subcommittee as we expand choices available to beneficiaries without compromising quality, access or value.

Chairman THOMAS. Thank you very much, Mr. Vladeck.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I welcome you to this hearing, Mr. Vladeck. I will have to say I am stunned by your testimony and disappointed by your comments. Some weeks ago you came to visit me in my office to talk about this matter. This bill passed many months ago; it was only a 6-month extension. You know as well as I know that it has to be done in 4 months or the products will be off the market. We cannot pass a bill at the end of the 6 months, the last day of the 6 months, and expect the market to be there.

There are 400,000 American seniors who have chosen this option. There must have been a reason. They were not compelled. As you said in your own testimony, managed care is going to succeed or fail in the senior population depending on their choice, and if they think it offers them something and they like it. Now 400,000 seniors have chosen Medicare Select.

We have now very few months of the 6 months' period left. We have maybe 1 month left to get this through so the products don't go off the market. You came to see me in my office to talk about this, and I appreciated that courtesy and I told you that at the time. Thereafter I wrote you a short letter saying I appreciated your visit, we must get down to the specifics, what is it you don't like, what would you like changed in the legislation, what are your concerns specifically, let's get to it. Thereafter, your staff called me and asked what questions I would like to have you answer.

Well, you have talked about your work in the Medicare program. It is a very big program, it is a powerful program, it is one of the most important benefits to American seniors, and nobody knows that better or cares more about it than the members on this committee, regardless of party, and I am pleased that you are making some progress. But I am very interested that the charts you used to talk to us about Medicare are 1992 data. This is 1995. Anyone involved in health care knows how rapidly the market is moving. Anyone involved in health care knows that health care costs are being contained in managed care and consumers are liking it because they are continuing to choose it and show positive responses on polls.

Now, that is not to say there are no problems, and in my office I agreed with you that there are problems, and we must look at those, but you did not do that today, and if you are going to be part of this dialog, buckle down, get your staff focused, and let's do it. Now you said in your testimony that Medicare Select will increase costs to Medicare.

Now, I want you to define for me to what extent is that the result of our failure to deal with things like the AAPCC and other structural problems in the way we price in Medicare and the way we contract with the private sector. Contracting is not new, I agree with you, contracting could be a good answer, why aren't we out there? Why have we let 3 months pass? Why aren't we going to try that in Medicare Select? I hope your people will stay because we are going to have excellent testimony that Medicare Select offers seniors more access to prescription drugs, offers seniors some access to dental and vision care. They aren't buying it because they are being forced to. They are buying it because it is a good bargain.

Mr. Schaeffer later on will provide us with real data that shows the use of in-network providers under the Medicare Select program in California saves the government money, specifically medical services per admission for network providers was 20 percent lower than for nonnetwork providers, and the average length of stay for network providers was 50 percent lower than for nonnetwork providers.

Now, does HCFA have different figures on this matter? Do you have any contemporary figures on this matter? What is your comment on California's experience, and how does it relate to your broad-brush comment that Medicare Select is increasing Medicare's costs?

Mr. VLADECK. Mrs. Johnson, let me say that we don't believe Medicare Select at the moment is increasing Medicare costs in general. All we know for sure is that, as far as we can tell, it is not decreasing our costs. My comment about increasing costs was a concern about extending Medicare Select discounting to part B services without some assurance that there were real networks out there——

Mrs. JOHNSON. The bill doesn't do that.

Mr. VLADECK. I understand that, and I didn't claim that the bill did.

Mrs. JOHNSON. So you are not claiming that the bill as written and before us will increase Medicare's costs?

Mr. VLADECK. No, we are not, Mrs. Johnson.

Mrs. JOHNSON. Now comment on California.

Mr. VLADECK. In regard to Mr. Schaeffer's plan, as I understand it, the Medicare Select plan that is offered by Blue Cross of California builds on an existing provider network that is exactly what we are trying to get in terms of real managed care and effective managed care choices.

Mrs. JOHNSON. Absolutely, Mr. Vladeck. I would remind you that Federal regulations require that Medicare Select provide a network that is sufficient to provide access to all the services for the provider, so what is going on in California in that regard is not unique, it is federally mandated.

Mr. VLADECK. I don't think that is entirely true, Mrs. Johnson. If you look at the RTI study, you will find that they found that the majority of Medicare Select plans during their preliminary evaluation did not have extensive networks outside of hospitals and that most of the hospital networks, as Mr. Pomeroy suggested from the experience in North Dakota, were comprised of essentially all of the hospitals in the State without the kind of real management of both utilization and care that Mr. Schaeffer's plan provides.

So our question is how to get more of the kind of benefits that are provided in the Select plans that meet the initial expectations people had for Select.

Mrs. JOHNSON. My time has expired, but you will note that Mr. Pomeroy also mentioned that Medicare Select plans are not allowed to include physicians, so, of course, they primarily include hospitals. It is the network itself that includes physicians that you draw them into.

My time has expired. I will remain and perhaps have another chance for questioning later on.

Chairman THOMAS. Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

Can you tell me, with the HI Trust Fund on its way to bankruptcy just after the turn of the century why the administration has chosen not to include this fact in its current budget and how the administration can tell us that they are concerned about the most vulnerable when they have blatantly ignored solutions to this problem?

Mr. VLADECK. I think there are appropriate places for discussions of appropriate issues. The trustees of the Hospital Insurance Trust Fund and the SMI fund owe a report to the Congress on April 1 of this year, which I expect will be before you are done with your budgetary deliberations for the next fiscal year.

We will obviously address both the short- and long-term solvency issues associated with the fund at that time, and we will be happy, once that report is out to discuss the recommendations in more detail. To do so in advance of the trustees' report would be premature.

Mr. ENSIGN. You mention in your conclusion about 70 percent of the insurance costs are paid for with premium payments. Is that 70 percent of the total medical costs or just the insurance?

Mr. VLADECK. Seventy percent of the Medicare benefits.

Mr. ENSIGN. Are total Medicare benefits paid for through, and that is the average person that is receiving them now through their lifetime of payroll taxes, what they have paid in, what they are paying on their copays?

Mr. VLADECK. The estimate is not derived that way, sir, because of the problem of how you impute earnings on a trust fund. About 60 percent of Medicare benefits are paid from the Hospital Insurance Trust Fund and 25 percent of part B benefits are paid by premiums; between the two, you get 70 percent that is financed either through payroll tax or through beneficiary premiums. Now, those payments only account for about half the medical expenses of Medicare beneficiaries.

Chairman THOMAS. Would the gentleman yield on that point? Because I think it is important.

Mr. ENSIGN. Yes.

Chairman THOMAS. If I say this another way, is this what you are saying, that you used the term 70 percent, and that is the insurance cost to the beneficiary, that they pay about 70 percent?

Mr. VLADECK. They have contributed over their working lives.

Chairman THOMAS. Of the insurance?

Mr. VLADECK. Or they are now paying 70 percent of their insurance costs.

Chairman THOMAS. But the health care costs to Medicare are not the 70-percent figure?

Mr. VLADECK. The health care costs to Medicare are the 70 percent, but the benefits, the total health care costs of the beneficiaries, are substantially more because of the limitations on Medicare's benefits.

Chairman THOMAS. We will pursue that.

Mr. ENSIGN. Actually, even to pursue that further, is this the people that are currently receiving it because obviously the Medicare premiums on payroll taxes and everything have gone up, is that taken into account, the amount that they paid over time, or are you extrapolating somebody that is earning a living now by the time they get to 65 years of age?

Mr. VLADECK. We are talking about a pooled trust fund, and we are saying that probably in the future, with all things being equal, they would be somewhat lower because the proportion of total expenses for Medicare part A is shrinking relative to part B.

Mr. ENSIGN. But you are not looking at the average person that has been contributing for the last 40 years. That is what I am trying to get at.

Mr. VLADECK. For the average person who is currently a beneficiary, 70 percent of the costs of their Medicare benefits are financed from the pooled contributions of people who contributed to the program since it began plus their beneficiary premiums.

Mr. ENSIGN. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from Washington will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I admire your politeness, Dr. Vladeck. New Yorkers are known for that.

Mr. VLADECK. It is great to set the record straight, Mr. McDermott.

Mr. MCDERMOTT. I think you might have pointed out to Mr. Ensign that the Republican proposal that has been put on the table actually makes the trust fund worse by raising the taxation exclusion from 50 percent to 85 percent, isn't that correct?

Mr. VLADECK. That would shorten the life of the trust fund, yes.

Mr. MCDERMOTT. So it is a little disingenuous to raise questions about the administration when the proposal they are putting on the table is making it worse?

Mr. VLADECK. As proposed, it would shorten the life of the trust fund, yes.

Mr. MCDERMOTT. There has been a lot of talk about the Medicheck proposal which the Speaker thinks we ought to put out for seniors. This Medicheck would send the seniors out with a voucher to buy health insurance, it would get rid of this big bureaucracy of 4,000 people that run Medicare. We know that per capita right now Medicare is spending $4,400 and change for a beneficiary.

Do you think my 85-year-old mother could take that voucher out and buy roughly the same kind of care in the insurance market in this country that she has today under Medicare?

Mr. VLADECK. Certainly not in the insurance market that exists at the moment.

Mr. MCDERMOTT. Well, what would happen to her?

Mr. VLADECK. Well, again, it depends on how one did it. We have looked at so-called voucher proposals, and we believe that in order to avoid a serious, serious risk to the beneficiaries, you would need to do two things for which we just spent the last couple of years being seriously criticized.

One, you have to set some very stringent rules for how the insurance market would operate to make sure that the people with vouchers weren't redlined, that they weren't discriminated against in various ways, that marketers didn't sell selectively, and that there were various consumer protections.

And the other thing you would need to do is have a very sophisticated risk adjustment system, since $4,400 is an average cost per beneficiary and the dispersion of rates across the program is very, very substantial. For example, 5 percent of beneficiaries will incur expenses of $50,000 a year or more, and that is not just random.

We can predict with some accuracy, but not yet enough, that beneficiaries who are older, who have been in nursing homes, or who have a history of cancer, are more likely to incur very high expenses than the average beneficiary.

Mr. McDERMOTT. Would you speculate on what would happen to my father. My father has had a stroke, he has chronic heart disease, he has had cancer, skin cancers, a number of them. What would happen to him with that voucher and what would happen to the rest of us in the family?

Mr. VLADECK. Well, again, unless the voucher were actuarially priced to reflect his particular circumstances, which is a little hard to envision, what would happen to him is probably what would happen to people like my mother, who is still working in her sixties and trying to buy disability insurance on the private market.

An individual insurer has to be pretty dumb to sell an individual policy to somebody that risky. As an insurer for the highest risk part of the population, it is almost impossible to recoup one's—to cover one's risk, except by pricing at such levels that you would get publicly embarrassed when they ran in the newspaper.

Mr. McDERMOTT. So you are saying, really, that unless the Congress is willing to regulate the insurance industry very strictly and very stringently, this simply would be a shift of the cost on to the families and the beneficiaries, it would really be out-of-pocket costs from now on?

Mr. VLADECK. That would be our major fear about it.

Mr. McDERMOTT. I want to enter a letter in the record, and I ask unanimous consent. It was a letter sent to me by somebody who lives in Lancaster, Calif.

He says when his COBRA benefits expired, for which he paid $3,300 a year, he tried to convert them at Prudential to a policy with a $1,000 deductible. It would cost him $12,366 a year with a $1,000 deductible. With a $100 deductible, he would have had to pay $20,000.

When I think of this as being a 59-year-old person trying to buy an individual policy out there with a voucher, something that they were buying in a group at $3,300, suddenly they are buying it individually, it seems to me the same thing is liable to happen to senior citizens when they are sent out as individuals to buy insurance in this present market.

Is that a fair assumption?

Mr. VLADECK. Medicare exists in the first place because before its existence, with the exception of group policies—mostly employer group policies—there essentially was no private market for health insurance for people 65 and over.

Now the world has changed and the demography has changed. One would expect the market to respond to the kind of arrangement you were describing by putting together a number of very attractive policies for younger, healthier beneficiaries. However, the problem of getting coverage for the older, sicker, and more expensive beneficiaries would be exactly the problem we are now having in the private sector where, unless they are employees or retirees of a large company, they can't get coverage.

Mr. McDERMOTT. I actually had my staff postulate that my mother was born in Ireland and was coming over to live in the United States and since she didn't have Medicare, we would try and buy private insurance. When I called the insurance companies, I got some amazing answers.

Blue Cross said, "Well, of course, we medically underwrite, and we wouldn't accept her if she had anything wrong with her," and Aetna actually told me that they would send me to Blue Cross. I mean, they weren't even willing to quote me a price. So I think that this is a very risky thing that is being proposed.

Thank you.

[No letter was received at the time of printing.]

Chairman THOMAS. The gentleman's time has expired and the subcommittee will recess until we go vote and then come back.

[Recess.]

Chairman THOMAS. Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Vladeck, it was my understanding that HCFA was charged with providing the Congress a report on Medicare Select and the demonstration on Medicare Select, and it is my understanding that the report was due last month; is that correct?

Mr. VLADECK. I honestly don't know, sir.

Mr. CHRISTENSEN. You don't know?

Mr. VLADECK. I don't know what the due date on the congressional report was.

Mr. CHRISTENSEN. I think it was due last month. I was wondering, do you know where that report is?

Mr. VLADECK. Again, we have provided a preliminary report. We have been advised by our evaluators that part of the delay is due to the fact that many States got the plans up and running a little bit more slowly than had originally been anticipated. As a result, it will be the latter part of this year before their evaluation is complete.

Mr. CHRISTENSEN. I am new to this process, and it is my understanding that you are in charge at HCFA, and the report was due last month, and you don't know where the report is, you don't know what it will say. Do you know what it says at this time?

Mr. VLADECK. No, sir. If we knew what the final evaluation said we could make more detailed recommendations. The preliminary report, which few have seen, describes largely the structure of the plans and their history.

The real questions for an evaluation have to do with comparisons of the populations enrolled in Select plans and populations that are not. That data analysis is currently underway, and we have been in conversation with the evaluators, but we can't yet give a precise date as to when their work will be finished.

Mr. CHRISTENSEN. Can you give a general date when you think we can expect to see the final version, since it was due last month?

Mr. VLADECK. The latter part of this year.

Mr. CHRISTENSEN. The latter part of this year?

Mr. VLADECK. Yes, sir.

Mr. CHRISTENSEN. I am sure this is not an example of the efficiency of the Medicare system being 10 months late, 9 months late, 8 months late.

Mr. VLADECK. Again, the major constraint on the evolution of this evaluation has been the way in which the plans have evolved in the various States and the regulatory apparatuses in the various States have evolved.

Mr. CHRISTENSEN. Two days ago, Congressman Steve Horn talked about the President's budget, and I would have to say I have not heard it put any better than when he said that this year's budget wasn't DOA, it was totally devoid of accountability, not dead on arrival like the last few budgets have been, and it was devoid of accountability because there was nothing in there regarding Medicare reform. The President totally passed the buck.

The editorials in my paper out in Omaha, Nebr., have heavily criticized the administration for not doing their fair share in this area. We are going to look at another trillion dollars in debt.

I wanted to know when the President called you and the administration asked for your input as far as your ideas, what did you say? Did you say let's let the Congress do it, let's let the Health Subcommittee make the tough cuts? What went on?

Mr. VLADECK. I think it is fair to say, sir, that we haven't had any particularly new conversations relative to the current year's budget proposal since we have been saying and believing the same thing consistently for the last year and a half. Any significant changes in the financing of the Medicare program ought to be addressed in the context of broader health reform strategies.

Last year we tried to make a very detailed proposal to the Congress that included changes in the Medicare program. We were less than fully successful. Given the new leadership and composition of the Congress, the President has already written a dialog about health care reform. Within that context we have always been very clear that changes in the Medicare program were an entirely appropriate part of those discussions.

Mr. CHRISTENSEN. It sure didn't show up in the budget. You did say "under the leadership of President Clinton" earlier in your remarks, and I would say that that is no leadership.

I wanted to ask you a specific question on the problems or incidents of the beneficiary dissatisfaction. Can you cite any examples that led you to the conclusion that we need more regulation on Medicare Select?

Mr. VLADECK. I can't provide you with specific anecdotes. Again, the general question of customer satisfaction will be addressed using survey information in the final evaluation for which we are waiting.

I should tell you, however, that because medicine is a free-choice circumstance, Medicare beneficiaries in almost every setting will report very high degrees of satisfaction. That is to say, our beneficiaries in HMOs are very highly satisfied with their plans, our beneficiaries in the fee-for-service system are very highly satisfied with their plans, and the anecdotal information suggests that Select enrollees are very satisfied with their plans. When you have circumstances in which people have a voluntary choice of enrollment, and in the HMO setting voluntary disenrollment, that is not a surprising result.

Mr. CHRISTENSEN. Well, with all due respect, Mr. Vladeck, you are the head of HCFA, you didn't know a report was due last month, you don't know when it is going to be on our table, you don't know what the conclusions are going to be in that report, and you can't give me specific evidence of various problems that have led you to conclude that we need additional regulation on Medicare Select. We need to get some answers. When you find those answers out, I would appreciate visiting with you and finding out what they are.

Mr. VLADECK. Again, as soon as the evaluation is complete, we will certainly share it with you, and in terms of the other questions you had, we will be happy to supply you with a more detailed answer.

[No information was received at the time of printing.]

Mr. CHRISTENSEN. Thank you very much.

Chairman THOMAS. Two followups to the questions asked by our two new members of the committee.

Mr. Vladeck, I am looking at the Omnibus Reconciliation Act of 1990 conference report to accompany H.R. 5835. On page 146 of that report, it is outside the courts but it is part of the law, which says the effective dates, amendments made by this section shall only apply in 15 States, et cetera.

> D. Evaluation. The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section and shall report to Congress on such evaluation by not later than January 1, 1995.

That is the law, and to ask you to further respond to the gentleman from Nebraska's statement, it is in here, the date was January 1, and the reason you are not complying with the law is what?

Mr. VLADECK. Mr. Chairman, I can't really comment at this time on a contract entered into in the previous administration, but I will be happy to provide the subcommittee with the detailed history involving the timing of the contract that we are now discussing.

Chairman THOMAS. OK. I just want to make sure that the statement that was made was a factual one.

I have a sheet that I want you to respond to as well in terms of the question from Mr. Ensign. Let the staff pass that out.

[The following was subsequently received:]

TABLE 5. LIFETIME MEDICARE BENEFITS, TAXES, PREMIUMS, AND TRANSFERS

(in thousands of constant 1993 dollars)

	PERSONS TURNING 65 IN 1995			
	Single Male	Single Female	One-earner couple	Two-earner couple
BENEFITS	75.0	110.7	185.7	185.7
TAXES & PREMIUMS	34.7	45.6	59.0	68.5
NET TRANSFER	40.3	65.1	126.7	117.2

NOTE: All amounts are discounted to present value at age 65 using a 2 % real interest rate. Adjusts for chance of death in all years after age 21. "Taxes and premiums" include the actuarial value of all employer and employee HI payroll taxes, all SMI premiums, and estimated portion of federal income tax burden devoted to financing SMI. Projections are based on HCFA 1993 intermediate assumptions, adjusted for the estimated impact of 1993 enactments. SMI premiums are assumed to remain tied to 25% of program costs after 1995. Recipients are assumed to receive Medicare insurance protection, in each year after age 65, which equals in value the average Medicare outlay per enrollee in that year. Individuals are assumed to earn average wages for their cohort.

Source: Based on Steuerle, E.C. and J.M. Bakija. *Retooling Social Security for the 21st Century: Right and Wrong Approaches to Reform.* Urban Institute Press, 1994.

Chairman THOMAS. I guess it is partly because I am somewhat confused by that portion of your testimony which indicated that. Under the conclusion which indicated that through their payroll contributions and those of their employers during their working lives and through their own premium payments, beneficiaries in fact contribute 70 percent of their insurance costs.

Now, the chart I have in front of me, and you obviously can react to and disagree if you so choose, represents 1993 dollars and obviously they would change slightly in 1994, they would change slightly in 1995, and in 1996; I think you will find they will begin to shift dramatically in terms of increasing the bottom line. But what we have here is a profile on persons turning 65 in 1995, single female, single male, one-earner couple, two-earner couple, benefits in terms of what they are going to receive under the program, taxes and premiums, the amount they paid into the program, and the net transfer which is the burden other than the beneficiary, that is, the taxpayers are going to pay for these individuals.

And I guess my problem was that when you said that individuals contribute 70 percent of the insurance costs, and I said, Is that the health care benefit paid by Medicare, I thought your response was at least not in a way that I could understand it.

Do you dispute the net transfer line on this chart that a single male will receive in essence a $40,000 benefit from the $75,000 benefits allowed in the program. The 34.7 that they would pay into the taxes and premium structure, and of course, as individuals, went up in terms of the amount that they put in, clearly the net transfer is even greater.

Mr. VLADECK. Until I know a lot more about the assumptions underlying this table, I couldn't comment one way or another, Mr. Chairman.

Chairman THOMAS. Well, nowhere do we see anything approaching a 50-percent payback.

I guess we are going to need more information on that statement because it is puzzling to me, too, because it runs contrary to what I have understood to be the problem. I guess if, in fact, these are the kinds of percentages people are paying into the program and the HI fund, which is clearly the most expensive part of the Medicare program, is actuarially determined to go belly up or bankrupt by 2001. Let me ask you the question in another way, currently is the payroll tax 1.45 percent?

Mr. VLADECK. That is correct.

Chairman THOMAS. And we removed the cap on all income to be taxed for that fund. What would be required either in terms of tax increase or benefit modification to make the HI fund sound beyond 2001?

Mr. VLADECK. I don't know offhand. Again, we are pointing toward April 1 for those analyses. If we have them available earlier, I would be happy to get them to you, but they will be part of the trustees' report.

Chairman THOMAS. It is my understanding that the tax rate would have to be at least tripled and benefits cut two-thirds to be able to attain a comfort level about the HI fund.

When you take a look at the employment profile of an open-ended tax tripling or the reaction of beneficiaries of two-thirds of their benefits being cut, it is a little shocking to me to find out that in the final year of President Clinton's ability to completely control a Federal budget, that virtually no response is made at all, either in terms of offering changes in programs or creative solutions to a problem that is squarely in the middle of the road less than 10 years away.

The gentleman from Wisconsin, if he wishes to inquire.

Mr. KLECZKA. Mr. Chairman, one brief question.

In your testimony, Bruce, you indicate that on average we pay about 6 percent more for every Medicare enrollee in managed care.

Mr. VLADECK. That is correct.

Mr. KLECZKA. The purpose of managed care, I thought, was to save dollars versus cost more than fee-for-service. Is there some problem with the reimbursement formula that this is occurring?

Mr. VLADECK. There are really two problems, and the major problem is the fact that our payments don't adequately adjust for the kind of selection effect we have in the Medicare risk program.

Mr. KLECZKA. The problem is healthier people are selecting managed care?

Mr. VLADECK. Yes. Significantly more healthy people go in than the average. There are some very good reasons for this. There is nothing terribly sinister about it. A large part of the Medicare risk enrollment is comprised of the folks who were enrolled in HMOs before they retired and want to keep their existing source of care.

Another thing that is a very important component of this issue is that people with more serious chronic diseases tend to be more likely to have established relationships with physicians who are not part—or historically have not been part—of HMO networks and are thus more reluctant to leave their existing patterns of care.

In addition, although it is much less of an actuarial effect, currently Medicare HMO enrollees can disenroll at will. This probably leads to some selection against us on the disenrollment side as well as the enrollment side.

Mr. KLECZKA. So what are we going to do about it?

Mr. VLADECK. We have a number of activities underway to try to address both of those issues. In the long term we need a more sophisticated payment method, and we are conducting a number of experiments now with alternatives. As I discussed in my testimony, we would like to test a competitive bidding model as well.

At the same time, to the extent that we can improve our quality monitoring and quality assurance technologies for Medicare risk plans, we probably should over time do away with the continual disenrollment policy; it doesn't work in our interest or in that of the plans, and it would minimize some of the selection effect as well.

Mr. KLECZKA. OK. Reading from Congressman Stark's opening statement, he indicates here that, regarding HMO Medicare coverage, we passed legislation in 1989 directing the Secretary to improve the payment system, but little progress appears to have been made.

Mr. VLADECK. Again, I can only comment on what has occurred in the last 24 months. There was very little progress before then. Since then, we have redirected a major part of our research and demonstrations budget in the direction of HMO payment methodologies.

We have also worked very extensively both with the trade associations in the industry and with individual plans to try to design demonstrations of new payment methods in managed care.

Mr. KLECZKA. Do you stipulate that the Medicare Select program does save enrollee costs, people in the program do save money?

Mr. VLADECK. It appears to. However, and I believe one of the subsequent witnesses will speak to this, it is not entirely clear the extent to which those cost savings arise from lower utilization and the extent to which they arise from the way the prices are age banded in certain States.

Mr. KLECZKA. But you don't agree with Mr. Schaeffer who will testify I think in the next panel, that Medicare Select does save the government money?

Mr. VLADECK. It is not clear to us. It clearly doesn't save us any money on the part A side. I wouldn't doubt that we save money on the part B side in his plan, but again I think that is atypical among the Medicare Select plans.

Mr. KLECZKA. Fine. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Bruce, in your testimony where in talking about the apparent anomaly, you stated, "In fact, if proposals to expand Select discounting to part B services are enacted, Medicare costs would actually increase, as physicians increase utilization to recoup their discounts."

Wasn't that an argument that was made in terms of the modeling profile when we put in the resource-based relative value scale plan? We had to watch out for surgeons and physicians because if we were going to cut them down on one side, they were simply going to increase visits and do more procedures so that they would make money. Didn't we discover that, in fact, all of our concerns harboring the cleverness of this particular group of physicians?

Mr. VLADECK. Well, that is correct, but we also put a backstop in the physician fee schedule in terms of the RBRVS so that the physician community was well aware that increased revenues from increased utilization would affect subsequent years' rates.

Chairman THOMAS. Then why wouldn't that simple fix solve the enormous threat that this appears to be in your testimony?

Mr. VLADECK. We would be happy to talk about a fix of that kind.

Chairman THOMAS. No, no, but you don't talk about it in your testimony. You create a bogeyman here where we anticipated and didn't see it as you said it anticipated with the backstop. This is the kind of a statement that permeates your testimony that causes me a lot of concern because I don't see any factual evidence.

I see theoretical concepts on models that have already been discounted. I just don't understand why this argument is presented as a realistic one for not going forward. Could you tell me why? Is this a real threat or did it just get thrown into the testimony?

Mr. VLADECK. This is a real issue, sir, that has been studied not only by our actuaries in OMB but also by the Inspector General when the Inspector General declined to provide a safe harbor for part B discounting.

I think your suggestion that we might use some of the techniques that we have used with the physician fee schedule to address those sorts of risks in Select plans is a very good one and we would be happy to think about ways to do that.

Chairman THOMAS. The discussion we had was about being overly aggressive earlier and that we have to be very careful. And in fact, recent evidence indicates that we are not saving money at all, and that we are getting a bit of an adverse risk selection by virtue of the program that we have now.

I think it really comes down to two basic philosophies, and I think we are beginning to understand where you are coming from, and that is one of the things that I have learned in trying to understand the mistakes the private sector made was that early on, they were too timid, they tried to just make minor adjustments, and it wasn't working. It wasn't until they got a complete understanding that you had to make a commitment to change the structure that you began to get the benefits in the private sector, and as we have seen recently in terms of modeling Medicare and the private sector, that in fact Medicare is actually an anchor, a drag on the changes that are occurring in terms of total costs. When I look at those charts, and Mr. Stark and others are anxious to run back to that period in the early nineties and talk about the fact that Medicare was leading the curve at that time.

I have tried to look at the numbers behind it, and my conclusion is that the reason Medicare was leading it was that there were a series of cumulative cuts made in the eighties and they were beginning to compound and that those reductions were leading the private sector but we have kind of ridden that wave. It is over.

Once again, returning to the President's budget, there is no significant understanding apparently that the private sector is going to continue to outstrip Medicare in terms of its changes unless we make some fundamental changes. What I hear in terms of your testimony is we are worried about some decisions that were made 10 years ago without any reflection for the world and how it has changed now or that we understand that what we have to do is more aggressively move into managed care, not more timidly. What I hear in your testimony is we need demonstration projects, we need to go slowly.

We are thinking about a PPO model, so that we drive choice in terms of the consumer. They get only one model; we don't take advantage of the knowledge that we have learned in the private sector to allow as many possible models and put the choice factor on the individual with clear understanding of thresholds and controls, given the type of people that we look at.

I am saying that in sum and substance of this testimony, I am looking at that black hole in 2001, and this administration with its clear actions in the budget, either in terms of reductions, which is the only way we have stayed close to the private sector curve, no reductions at all, no plan offered, but a very timid position in going forward.

And finally, before I let you respond, the gentleman from Washington continues to focus on one small aspect of the Republican plan for change, which was in the Contract. I, at one time, was quite proud of the fact that we were able to hold most of our health care ideas outside of that contract, not lock ourselves in rigidly to preconceived notions. We are going to offer a significant number of changes in this Congress. We believe one of those is the Medicare Select bill offered by Mrs. Johnson.

We are going to offer reforms in the insurance area, we are going to offer reforms in the malpractice area, we are going to take care of those problems that the Clinton administration in the last year refused to separate out from its goal to completely restructure the health care system in this country. Those changes should have been moved in the last Congress. We are going to do everything we can to move them in this Congress, but without a partnership as described by Secretary Rubin and Secretary Shalala between the two of us, we are not going to lay the groundwork to save this system.

I am just concerned about the timidity, about the failure of you folks to be even anywhere near as bold as you were in the last Congress about the need for change.

Mr. VLADECK. Mr. Chairman, if I could just make two observations in that regard. The first is that I think it is appropriate, when talking about what has happened in the last 18 months or so in the private sector, to also note that the way in which this administration has approached this issue since the President came into office is to recognize that there are two things going on in the private sector.

First, in the last 18 months, costs have been growing much more slowly; second, Americans are continuing to lose health insurance at the rate of 100,000 people a month. One of the reasons that private health expenditures are going up more slowly is because fewer people are being covered in the private sector. If you are going to talk about bold systemic change in this regard, you ought to put all of the important issues on the table, including the deterioration of private sector health insurance coverage, which continues to be a major concern and something we believe the Congress needs to work with us to address.

In that regard, when one talks about a boldness or timidity, I think the place where one should be most risk averse is with the one part of the population that has, in effect, universal health care that they are very well satisfied with. If we are going to take big risks with major changes in the health care system, I would suggest we are happy to work with you on more innovative and exciting ways to cover the 15 percent of the American population that has no health insurance whatsoever.

Chairman THOMAS. Mr. Vladeck, I did hear you just say that the reason that the private sector cost curve is going down is primarily because fewer people are covered?

Mr. VLADECK. I did not say “primarily.” I said it is one of the reasons.

Chairman THOMAS. Where would you place that in relation to the bold and dramatic decisions made by the private sector in moving toward and embracing managed care?

Mr. VLADECK. I think it has been much easier for the private sector to embrace the kind of managed care approaches they have as they have reduced the aggregate riskiness of the populations that are covered.

Chairman THOMAS. What percentage of the reduction would be credited with your position versus mine?

Mr. VLADECK. Since these numbers are floating around in a number of ways, I couldn't give you an off-the-top-of-the-head number.

Chairman THOMAS. How about ballpark? Sixty percent of the cost reduction in the private sector is because of their refusal to insure people?

Mr. VLADECK. No, I wouldn't say that.

Chairman THOMAS. Thirty percent?

Mr. VLADECK. In 1993, we are not talking about cost reduction, we are talking about reduction in the rate of growth. I would say if you compare total private expenditure rate of growth in 1992 and 1993—we don't yet have the 1994 numbers with per capita experiences in the insured community—what you find is about two-thirds of it is a reduction. But I wouldn't swear to these numbers. We will get you more precise numbers, but roughly two-thirds is a reduction in the per capita expenses of those who are covered and the rest of the acceleration has to do with the deterioration of coverage.

Chairman THOMAS. This is 1995 and next year 1996, and again I am looking at the timetable in terms of having to make big decisions because the big risks are out there. In my opinion, adopting those changes in the private sector for a government basically fee-for-service sixties program are not big risks. The big risks are not moving forward as rapidly as we can.

Mr. Vladeck, we have a kind of unusual next panel which is two former HCFA administrators, and it would be enormously helpful——

Mr. MCDERMOTT. Who are now insurance company executives, Mr. Chairman, so Mr. Vladeck has good things to look forward to.

Chairman THOMAS. I thought he was going to be devoted to this job for at least the foreseeable future.

Mr. MCDERMOTT. At least the next 6 years, I believe.

Chairman THOMAS. Mr. Vladeck, if you want a recommendation after 1996, November, come and talk to me. Now are we through with this? OK.

The request that I was going to make was that if at all possible, would your schedule permit you to hang around so that we can have a question and answer with the current and previous HCFA administrators, because that would be a very enlightening experience for us, if possible.

Mr. VLADECK. I am afraid I only have another 20 minutes or half an hour, and I don't know how you would want to structure that. I have some folks coming from out of town to see me at 1 o'clock.

Chairman THOMAS. If you aren't going to be able to do it, then I would yield to the gentlewoman from Connecticut for a question or two.

Mrs. JOHNSON. Mr. Vladeck, after the sentence that my Chairman read about Medicare costs would actually increase with Medicare Select, shortly thereafter in your testimony you say: "We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices." And you say this is an important issue and we will work with you and the subcommittee.

Now, on quality and access, there are Federal rules that your department has issued that say that the provider networks have to be sufficient, that emergency services have to be paid for, that quality assurance programs have to be out there, that seniors have to be clearly informed about the choice that they are making.

There are other Federal requirements that regulate the marketing of supplemental insurance policies in general, that deal with waiting periods and preexisting conditions, establish minimum loss ratios and create premium refund provisions in the event that the minimum loss ratios are not met, and so on and so forth. There is quite extensive Federal regulation already governing these plans.

There are also State regulations, and the State regulations address things like rate setting, loss ratio compliance, financial solvency, the extent of provider networks, and the measures of quality assurance, to name only a few.

What evidence would you present to this committee that those two levels of regulation have failed to assure quality and access issues under Medicare Select?

Mr. VLADECK. Well, again, Mrs. Johnson, to have more than hypothetical evidence we really need some systematic research results that we will certainly have for the subcommittee within 1 year of the statutory due date.

Mrs. JOHNSON. Mr. Vladeck, we passed this several months ago. There are only 15 demonstration projects. There are not a lot of plans doing this. And I would think that if you are recommending in your testimony only a 6-month extension, you ought to have some evidence.

Why not just make it permanent, put it out there? It is one of the quick things we can do to begin opening up the system, and let's gather the information.

But you heard the testimony of Mr. Pomeroy during the time he was intimately involved with this program. He never had a single complaint. In the material about Alabama, they don't say that they had any consumer complaints.

So I really ask your department to give us some concrete evidence on the very issues that you raise in your testimony and as we go forward to either support this bill or oppose it.

Mr. VLADECK. Let me only say that we do have a couple of concerns in that regard. We have had some preliminary conversations, and we will be happy to work with you to further identify what they are.

Mrs. JOHNSON. It has been several months and I would hope that preliminary conversations would move forward rapidly, and I would be happy to be a party to any of those.

Thank you.

Chairman THOMAS. Mr. McDermott, did you want to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

You mentioned that part of the cost reduction is due to less people being covered. Isn't it also a big factor that we had a big debate for 2 years in which everybody was a little worried about what was going to happen, and third, the big companies are now much more aggressively willing to shift costs on to the smaller companies? Aren't those also big factors in the reduction in costs?

Mr. VLADECK. I suspect they are. Part of the problem is that this alleged revolution in health care is being established on the basis of only about 18 months of experience. It is true that in previous periods in which Congress was seriously debating major health care legislation, there was a significant deceleration in the growth of private sector health care costs.

So we don't know if what happened in 1993 and 1994 is a permanent change or a blip, and we have asked our actuaries and others who estimate national health expenditures for their opinion; they say, "Well, on the one hand, on the other hand." It is really too soon to say whether the world has been permanently transformed or whether these are transient changes.

Mr. MCDERMOTT. Let me ask you about one specific program in HCFA so—or in Medicare. Do I remember correctly that the end-stage renal disease program is the largest single-cost center in the whole program?

Mr. VLADECK. Yes, on a per capita basis. Since there are only about 80,000 enrollees with end-stage renal disease, the basic Medicare program is obviously more expensive; however, our end-stage renal disease patients are far and away the most expensive on a per capita basis.

Mr. MCDERMOTT. Now, can you imagine those people going out and buying insurance with a voucher from an insurance company?

Mr. VLADECK. Mr. McDermott, once again, the reason a Federal program for end-stage renal disease was created is that when the technology to save the lives of people with end-stage renal disease emerged, people were unable to afford it and they were unable to find insurance coverage to pay for it.

Mr. MCDERMOTT. I remember the start of that program. It started in Washington State, and they had a little plan there, and somebody went to Warren Magnuson and thought it was a good idea, who then mumbled it through the U.S. Congress and it got to be the biggest problem in health care, in Medicare.

What it sounds like to me you are saying is that if we privatize Medicare, as we are sort of going here with the Select program, the opening wedge to privatize, that what is going to happen is we are going to wind up with a lot of very sick people that nobody wants, and we are still going to have a Federal program to cover them, while the insurance companies will have skimmed off all the healthy seniors. As soon as they are sick, they will be plopped back into the government program.

Is that a fair way to look at it?

Mr. VLADECK. That is a very real concern, yes, sir.

Mr. MCDERMOTT. To me that seems like the only way this is going to work because all the evidence I know suggests that all the managed care plans for senior citizens are basically skimming. They are figuring out ways to attract people who are healthy, and it isn't saving money for our program.

In fact, as Mr. Kleczka has pointed out, it is costing a little bit more, and that to extend that out to everybody is simply going to let the insurance companies kind of look through the elderly and try to find those who aren't going to cost them anything and take them and leave the rest for us, and that really is going to make our problem at the Federal level worse because we will look like we are never controlling costs if all we are dealing with are the sickest people.

Mr. VLADECK. Again, I think if you look carefully at the experience for the nonelderly population in this country over the last 5 or 10 years, you find that on a very small scale some of that has occurred in the sense of the enormous growth in Medicaid, and in Medicare enrollment of disabled folks, and again in the significant shrinkage, much of it at the high end of the risk scale, in terms of the extent of private coverage.

Again, one would think that in a rational market, unless it was highly regulated, people who were predictably the highest risk would have the greatest trouble—or would at least face the greatest out-of-pocket cost—getting good insurance, if they could get it at all. And again, in the Medicare population, the people of highest risks are systematically those with the lowest incomes.

Mr. MCDERMOTT. It seemed in my experience in the State legislature we created a high-risk pool because those people were out there floating around, and finally we just said, OK, at the State level we are going to deal with those people who don't fit Medicare, don't fit Medicaid, but they are still out there bringing in all kinds of costs, so we put them into our own high-risk pool.

And it seems to me that is where we are headed. The government is going to be stuck with the sickest people.

Thank you for your testimony.

Thank you, Mr. Chairman.

Mr. VLADECK. Thank you.

Chairman THOMAS. Mr. Vladeck, for you to indicate that the trends that are going on in the private sector are probably a blip and that we aren't collecting enough data to begin to have any comfort level for any change, runs directly counter to Dr. Altman's testimony not once but several times before this committee, in his analysis of trends that are out there.

Now, obviously I happen to agree with Stuart that these are permanent changes. I just find it ironic that when you want to and the gentleman from California wants to talk about a comparison for Medicare, you are forced to do a reach back of the last decade to talk about how great Medicare was, when it was clearly a cost shifter in the system. When you talk about savings in Medicare it was that the private sector was absorbing the costs of the program and now that the private sector has figured out they aren't going to be the patsies anymore, you are now telling me that you don't want to be aggressive in changing the system that is the anchor dragging down the rest of the system. It just seems to me that in your career—and I am rethinking this letter of recommendation that I talked about——

Mr. MCDERMOTT. I will write one for him.

Chairman THOMAS. Yes, it will be the opening wedge. I just don't want you to be the John Hammond of the Medicare world. He is the fellow in "Jurassic Park" who thought that he ought to bring back dinosaurs after their time has passed.

I would urge you not to take this dinosaur of a program and go slow and be timid and pretend there are blips out there.

I see an enormous chasm in 2001. Your President apparently does not. There are no substantive changes in the budget and dollar amounts to help meet the cost. There are no creative programs in the budget to meet the cost. I thought your testimony today would at least provide some slight hope that you folks would understand that the dinosaur in the health care system today is Medicare and it needs changes.

You ought not to nurture it. You ought to go see the movie if you haven't read the book. There are enormous dangers in not moving, and there are enormous dangers in kidding yourself that what is going on out there in the private sector is a blip.

Mr. VLADECK. Mr. Chairman, if I remember the movie and the book correctly, part of the issue is the danger of experimenting in areas where you really don't know what you are doing. I am afraid that our evidence, based on the experience of the Medicare population, about the performance of managed care for the Medicare population is at some variance with the evidence on the performance of Medicare for privately insured groups. In order to move Medicare in the direction of the private sector, we need to learn a great deal, which we are busily engaged in doing from the most successful practitioners in the private sector. We are finding out what they are doing that we have not been able to do, some of which we may be unable to do because our populations are so different.

Chairman THOMAS. And we thought that at least going forward with the Medicare Select program would be a modest attempt to learn more.

You obviously see it as a significant and dangerous risk, and I think there is the difference. For you to advocate a 6-month extension with no expansion of the program is to tell me where your thinking is.

So I would hope that you could have stayed. Obviously you have got some people to see at 1 o'clock and more important to make that appointment with those folks than to interact with the committee. I didn't tell you about it ahead of time, so it is partially unfair for you to think that a request would be made to interact with former HCFA administrators.

I look forward to sitting down with you. We have had some private meetings which I thought were rather fruitful. Something happens between the private meetings and the public meetings, as indicated by Mrs. Johnson. We will continue to try to work to take some of the discussions we have had in the private meetings and try to get them on the record somewhere. I understand the pressures you are under, Mr. Vladeck, and I look forward to working with you.

Mr. VLADECK. I look forward to working with you.

Chairman THOMAS. Thank you very much.

Mr. VLADECK. Thank you.

Chairman THOMAS. Next panel will be Bill Roper and Leonard Schaeffer, who are former HCFA administrators, and who apparently have taken their knowledge acquired in this taxpayer-supported position and have carried it over to the private sector. I think there has been a very fertile cross relationship that we are going to hear about at this time.

Dr. Roper, you can begin your testimony. Your written statements, both of your written statements, will be made a part of the record, without objection, and you can proceed for 5 minutes in any way you see fit to enlighten the committee.

STATEMENT OF WILLIAM L. ROPER, M.D., M.P.H., SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, PRUDENTIAL HEALTH CARE SYSTEM ON BEHALF OF PRUDENTIAL INSURANCE CO. OF AMERICA, INC.

Dr. ROPER. Thank you.

Mr. Chairman and members of the committee, it is a delight for me to be before you today. I am Bill Roper, senior vice president, chief medical officer of the Prudential, and I was HCFA administrator from 1986 to 1989. We look forward to welcoming Bruce Vladeck to the society of former HCFA administrators.

Let me commend you, Mr. Chairman and the committee, for taking on such a challenging and important issue for our Nation.

The message that I have for you today is that the health care delivery marketplace has evolved dramatically since Medicare was created, yet Medicare has not made similar progress. It is a sixties old style fee-for-service system that does not allow the elderly and disabled the opportunity to participate in current systems for delivering health care. The good news—and it is good news—is that it can be fixed by offering new alternatives to seniors without engineering a totally new system.

As you push aggressively on a cost constraining agenda for the Medicare program, I urge you to allow Medicare beneficiaries and providers an attractive alternative based on innovation in the private sector.

This isn't a new idea. I included in my testimony a piece I wrote for the Wall Street Journal in 1987 when I was at HCFA entitled "Medicare's Private Option." The message then and now was simple: Keep Medicare intact, but increase the choices available to Medicare beneficiaries by expanding the role of private-sector health plans in meeting their needs.

I oppose forcing older Americans to leave traditional Medicare in favor of private plans. What I do support is offering them choice. Don't take away traditional Medicare, just give them choice.

When that Wall Street Journal piece ran, President Reagan believed that well-managed private health plans offered an attractive alternative to traditional Medicare coverage. We were committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Under President Reagan's vision for Medicare reform, we at HCFA advocated this private health plan option based on five goals: Insuring appropriate access to quality care; increasing incentives for efficiency; reducing the government's role in deciding how much to pay; reducing government's role in deciding what constitutes appropriate medical practice; and expanding choices. These goals, I believe, are much in keeping with the goals of this committee.

I think that our plans in the mideighties were a good start, and there are signs today that the marketplace is responding.

At my company, the Prudential, we have health plans with Medicare risk contracts, with growing numbers of members in four States—California, Ohio, Florida, and Texas. We are able to offer an array of services over and above regular Medicare coverage, such as prescription drugs and routine physicals. There are many fewer worries for members, especially less paperwork.

The experience of our plans and others like them in the private sector has been positive for both Medicare beneficiaries and the plans, but these plans haven't flourished to the degree that they could because of three problems. Many of us have long recognized the problems inherent in the payment methodology for these plans, and I would be happy to elaborate later on that.

Second, Medicare beneficiaries have no incentive to choose a managed care plan except in instances where additional benefits are provided.

And third, the definition of a managed care plan is unduly restrictive.

I believe with the work of this committee, as you have outlined it, and the positive atmosphere for change, there is a ripe opportunity now to complete the journey toward a modern Medicare system that is integrated with the private health care system. Rather than having the government mandate what care should be provided, let the beneficiaries and their doctors and other practitioners be the judge; let them choose among various plans on the basis of which plan they believe is best for them.

Surely there ought to be standard quality and performance measures with public information and accountability. All of these reforms can work on a much bigger scale if the cumbersome statutory impediments are removed, if HCFA makes the process straightforward for the players involved, and if we are not shackled in our ability to do what we do best—organize and deliver quality health care services.

Managed care works. Witness what the private sector is doing today. Don't be distracted by studies based on old data. Look at what is happening today in the private sector.

To sum up, I don't support doing away with the traditional Medicare program, but rather offering much more choice to Medicare beneficiaries.

Mr. Chairman, I urge you, as you were saying earlier, to be bold. Many will tell you that this is difficult, and it is, and they will tell you that it is complicated, and it is, but I would urge you strongly to be bold.

Thank you, sir.

[The prepared statement and attachment follow:]

TESTIMONY OF WILLIAM L. ROPER, M.D.
PRUDENTIAL INSURANCE COMPANY OF AMERICA, INC.

Thank you Mr. Chairman and members of the committee for this chance to share with you some of my thoughts on opportunities for the Medicare program.

First, I would like to commend you, Mr. Chairman, and the committee for taking on such a challenging and important issue for our nation. Assuming a leadership role and being open to new ideas on how to improve the way in which America's Medicare beneficiaries receive health care takes much courage and foresight. So I am particularly pleased and honored to be here.

The message I have for you today is that the health care delivery marketplace has evolved dramatically since Medicare was created, yet Medicare has not made similar progress. Medicare is a 1960s, old-style fee-for-service system that does not offer the elderly and disabled the opportunity to participate in the current systems for delivering health care.

Medicare gives its beneficiaries very limited choice of whether to participate in the innovative organized health care delivery systems that have developed over the last 30 years. Not only is choice missing, but the cost of the program continues to consume a huge portion of federal spending. In 1980, less than 6% of the federal budget was spent on Medicare. In 1996, if nothing is done, Medicare will approach 12% of the federal budget.

The good news is that it can be fixed by offering new alternatives to seniors, without engineering a totally new system.

As you push aggressively on a cost-constraining agenda for the Medicare program, I urge you to allow Medicare beneficiaries and providers an attractive alternative based on innovation in the private sector.

My feelings on how to update Medicare have not changed since I was the Administrator of the Health Care Financing Administration. In 1987, I published an article on the Wall Street Journal editorial page on this subject, entitled "Medicare's Private Option." Major credit for it properly goes to my colleague, Glenn Hackbarth.

The message was simple: keep Medicare intact, but increase the choices available to Medicare beneficiaries by expanding the role of private sector health plans in meeting their needs. Private plans, including managed care and indemnity plans, would compete on the basis of quality and cost.

I oppose forcing older Americans to leave traditional Medicare in favor of private health plans. What I do support is offering them choice. Do not take away the vanilla-variety Medicare system. Just give beneficiaries a choice.

Back when that Wall Street Journal piece ran, President Reagan believed that well-managed private health plans offered an attractive alternative to traditional Medicare coverage. We were committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Under President Reagan's vision for Medicare reform, we at HCFA advocated this Private Health Plan Option, or PHPO, based on five goals:

- Ensure appropriate access to quality care;
- Increase incentives for efficiency;
- Reduce government's role in deciding how much to pay for individual health care services;
- Reduce government's role in deciding what constitutes appropriate medical practice; and
- Expand the range of choices available to both Medicare beneficiaries and health care providers.

These five goals -- quality, efficiency, less government involvement in pricing and practice, and more choice -- seem to be compatible with the goals of this committee. And I highly recommend them as guiding goals in any effort to modernize Medicare.

The plan recognized that government played too intrusive a role in the health care system, and that a far better approach would be to give both Medicare beneficiaries and health care providers the option of participating in Medicare through private health plans, because this was and is where innovations in the health care delivery system occur. Those private plans, within broad constraints set by the federal government, could determine their own methods for paying physicians and hospitals, for controlling utilization, and for ensuring quality.

I think our PHPO plan was a good start, and there are signs that the marketplace is responding. At the Prudential, we have Medicare risk-contracting plans with a growing number of members, so far in four states -- California, Ohio, Florida, and Texas. We are able to offer an array of services over and above regular Medicare coverage, such as prescription drugs and routine physicals. As important, with these plans members don't need to worry about unplanned medical expenses. And the paperwork that Medicare beneficiaries find so burdensome is dramatically reduced in this environment.

The experience of our plans and others like them in the private sector has been positive for both Medicare beneficiaries and the plans. However, the plans have not flourished to the point of providing marked savings to Medicare because there are serious barriers to full private health plan integration.

We can only offer these plans through Medicare's health maintenance organizations and competitive medical plans rule. This provision does not fully foster private health plan participation because:

- Throughout the United States, the Medicare managed care payment rate is based on the Average Adjusted Per Capita Cost (AAPCC) in each area. Many of us have long recognized the problems inherent in this payment methodology, including fairly reflecting what Medicare is paying in the fee-for-service system, and adjusting payments for a beneficiary's particular health status.

- The Medicare beneficiary has no incentive to choose a managed care plan except in instances where additional benefits are provided. And a managed care plan whose health benefit costs are lower than the AAPCC cannot reduce its price, but rather must make up the difference with increased benefits. This not only costs the government more but also does not encourage the senior to be a prudent purchaser.

- The definition of a managed care plan is unduly restrictive, and does not allow the flexibility generally to offer such plans as POS and PPO's, with the exception of the 15 Medicare Select States, and that is only for Medigap coverage.

Because of the way in which the rates are set, the lack of incentives for beneficiaries, and the definition of managed care plan, only a few Medicare beneficiaries are now able to obtain the benefits of managed care.

The nation has taken a half step toward the goals I outlined earlier. With the work of this committee, and the positive reform statements of Speaker Gingrich, there is a ripe opportunity to complete the journey toward a modern Medicare system that is integrated with the private health care system.

Rather than having government mandate what care should be provided, Medicare beneficiaries and their doctors and other practitioners are the best judges. Let them choose among various plans on the basis of which plan they believe provides the most appropriate care. And there ought to be standard quality and performance measures, with public information and accountability.

To accomplish this, Medicare beneficiaries should be given a voucher from the government to choose among the full spectrum of health plan options that many private sector employees now enjoy.

Initial voucher amounts should be based on an improved AAPCC methodology. As soon as a sufficient number of managed care plans have entered a local Medicare market, HCFA then should set the voucher amount at the average price of the health plans in that area, based on a bidding process. Plans whose rates are above the designated voucher amount would charge beneficiaries the premium difference, whereas plans whose premiums are below the voucher amount could rebate the difference to the beneficiary.

All of these reforms can work on a much bigger scale if cumbersome statutory impediments are removed, HCFA makes the process straight forward for all players, and we are not shackled in our ability to do what we do best: organize and deliver quality health care services.

Medicare beneficiaries will need to have useful and valid means of assessing quality and value across the competing health plans, so that they may choose the right one for themselves. Accreditation by groups such as the National Committee for Quality Assurance (NCQA), and performance measurement tools such as Health Plan Employer Information Set (HEDIS), would provide consumers the tools to make informed choices.

To sum up, again, I oppose forcing older Americans to leave traditional Medicare in favor of private health plans. What I do support is offering them choice, and making it easier for them to exercise that choice. Do not take away the vanilla-variety Medicare system. Just give beneficiaries a choice.

And further, this strategy fits with your efforts to constrain the cost of the traditional Medicare program, giving beneficiaries the incentive to make cost-effective choices for themselves.

The bottom line is that private plans can prove effective in meeting the needs of Medicare beneficiaries, and as they do, Medicare will be gradually converted into a cost-effective, quality program based on private plans.

Thank you Mr. Chairman and members of the committee for your time. I would be happy to answer any questions you might have.

THE WALL STREET JOURNAL FRIDAY, APRIL 3, 1987

Medicare's Private Option

By William L. Roper

When President Reagan asked Congress in February to expand Medicare to include coverage against the high cost of catastrophic illness, some conservatives condemned the president's decision, arguing that private insurers are adequately meeting the needs of senior citizens. By endorsing expansion of Medicare, a pillar of the federal establishment, the president had, according to these critics, sounded the death knell for the Reagan Revolution.

With few exceptions, the press coverage of this story ignored an essential point: Both the president and the secretary of health and human services, Otis Bowen, favor expanding the role of private health plans in meeting the needs of Medicare beneficiaries. The president and the secretary both believe that well managed private health plans can offer an attractive alternative to traditional Medicare coverage. The administration is committed to giving private health plans a fair opportunity to compete for Medicare enrollees.

Enrollees Total 860,000

Under the administration's Private Health Plan Option (PHPO), the federal government makes lump-sum monthly payments to private health plans enrolling Medicare beneficiaries. All participating health plans must meet certain minimum requirements on benefits, financial solvency, quality and other relevant criteria. In exchange for the monthly payments, the private plan assumes both the financial and medical responsibility for ensuring that its Medicare enrollees receive all medically necessary services. Enrollment is optional, all beneficiaries have the option of remaining in traditional Medicare, or of returning to Medicare on short notice. In the roughly two years since the option was first made available, about 860,000 Medicare beneficiaries have opted to enroll in a private health plan.

The federal government pays private health plans 95% of what it would have cost the government to cover the services in the Medicare benefits package. Since some Medicare beneficiaries use more services than others, the payment is adjusted for key characteristics of the enrollee, including age, sex and place of residence. A fair-payment formula is crucial to the success of the PHPO. If the formula overstates the cost of providing services, federal expenditures will increase. If it understates those costs, private plans will refuse to participate. The administration is therefore investing heavily in the effort to refine the rate-setting adjustments.

Unlike so-called Medigap plans, the plans participating under the PHPO cover the complete package of services now covered by Medicare, plus any additional services they choose to offer. Under the PHPO, in short, private plans do not simply supplement Medicare coverage, they replace it.

The government polices the market, channeling competition to achieve socially desirable ends.

The PHPO is an essential element of the administration's Medicare strategy. The policy is designed to achieve five goals:

- Ensure appropriate access to quality care
- Increase incentives for efficiency.
- Reduce government's role in deciding how much to pay for individual health-care services.
- Reduce government's role in deciding what constitutes appropriate medical practice
- Expand the range of choices available to both Medicare beneficiaries and health-care providers.

The administration—albeit reluctantly—also must continue its "prudent-purchasing" approach. Under this approach, the federal government remains in its traditional role as insurer of health-care services for the 31 million aged and disabled Americans covered by Medicare. As the insurer, it is obliged to set rules on how much it will pay for individual services and to determine what services are covered. Examples of the prudent-purchasing approach include the prospective payment system for paying hospitals and scrutiny by peer review organizations. Such organizations review services to ensure their necessity and quality.

So long as it remains an insurer, the federal government has no choice but to become a more prudent, and aggressive, purchaser. Medicare will spend roughly $80 billion this year. Notwithstanding the considerable publicity given the "budget cuts" imposed on Medicare, Medicare spending has been rising faster than the general rate of inflation or even the rate of increase in nominal gross national product. But whatever its budgetary merits, the prudent-purchasing approach has the unfortunate consequence of inexorably leading to ever-deeper federal involvement in pricing and medical decisions.

Critics of the PHPO often question whether private health plans should be trusted with so important a mission. Their concern is understandable, and the administration does not advocate blind trust in the ability of "the market" to meet the health-care needs of older Americans. Under its PHPO initiative, government polices the market, channeling competition to achieve socially desirable ends. By the same token, however, the proponents of ever-increasing government control over pricing and medical decisions should acknowledge the risks of that approach. The federal government wields so much purchasing power that it can be a destructive force, even when well-intentioned.

Medicare accounts for 40% of the revenue of a typical hospital; for many hospitals, Medicare's share is much larger. Hospital administrators understandably find it difficult to say "no" to such a powerful customer. The administration fears that government may inadvertently coerce health-care providers to take steps jeopardizing the interests of their patients. That is a real risk when so many decisions are made centrally, far removed from the affected providers and patients.

A far better approach is to give both Medicare beneficiaries and health-care providers the option of participating in Medicare through private health plans. Those private plans, within broad constraints set by the federal government, could determine their own methods for paying physicians and hospitals, for controlling utilization, and for ensuring quality. There is no single right answer to these questions. It is therefore entirely appropriate to permit organizations to experiment with different approaches.

Approximately a third of Medicare beneficiaries live in parts of the country where they currently have the option of enrolling in a private health plan. Two types of plans are now eligible: health-maintenance organizations (HMOs) and competitive medical plans (CMPs). Total enrollment in private plans has increased more than 60% during the past 12 months.

The administration does not expect Congress, Medicare beneficiaries or health care providers to support the PHPO out of allegiance to the abstract concepts of "the market" or "privatization." It asks them instead to support it because it will make the U.S. health-care system fairer and more efficient, while simultaneously protecting the quality of care.

Offering a Choice

To the extent that they can control costs more effectively than Medicare, private plans offer benefits not covered by Medicare. For example, HMOs and CMPs enrolling Medicare beneficiaries often charge lower deductibles and patient co-payments than traditional Medicare, and cover services (such as outpatient prescription drugs) not covered by Medicare.

The administration does not favor requiring older Americans to leave Medicare in favor of private health plans. It only wishes to offer them, and health-care providers, a choice. In other words, it seeks a fair market test for the PHPO. If private plans prove effective in meeting the needs of Medicare beneficiaries and health-care providers, Medicare will be gradually converted into a program based on private plans. If private plans cannot compete effectively with Medicare, the traditional Medicare program will remain the financing mechanism for the vast majority of senior citizens.

Dr. Roper is administrator of the Health Care Financing Administration.

Chairman THOMAS. Thank you very much, Dr. Roper.

Mr. Schaeffer.

STATEMENT OF LEONARD D. SCHAEFFER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BLUE CROSS OF CALIFORNIA

Mr. SCHAEFFER. Good morning, Mr. Chairman, and thank you for the opportunity to be with you this morning. I would like to ask that my prepared oral statement and written statement be included as part of the hearing record.

Chairman THOMAS. Without objection.

Mr. SCHAEFFER. The Medicare program has accomplished an enormous amount in the last 30 years. As we contemplate changes, we must keep this in mind. We also have to recognize that the program is built on a 1965 fee-for-service model that has not kept up with developments in the private market, namely the move to managed care.

In my limited time this morning I would suggest that the committee focus on restructuring two components of the Medicare program. First, the Medigap market for supplemental benefits, and second, the way that Medicare purchases benefits.

The Medigap market provides one opportunity for immediate action. In this market millions of seniors make local choices about their health care coverage based on real local options. We can harness those local market forces to the advantage of the Medicare beneficiaries and the Federal Government. We need to create a more competitive supplemental market by allowing more choice, especially choice built around managed care alternatives.

Our experience with Medicare Select shows that managed care, including PPOs, lowers costs to beneficiaries and to the government. Medicare Select also improves quality, and expands access to providers beyond those that accept Medicare assignment.

Let me briefly describe our Medicare Select program. Medicare Select from BCC in California is a Medigap PPO. Individuals retain basic Medicare coverage and can still go out-of-network. It is the best of both possible worlds.

The PPO network is made up of carefully selected hospitals, including some of the State's premier institutions, such as Stanford University, and 40,000 physicians. For hospital care, the beneficiary pays no part A deductible in-network; however, they can still go out-of-network but have to pay the deductible.

For physician service, in-network, we cover the $100 part B deductible, and there is no balance billing. Copayments are limited to $5 per visit. Out-of-network, the beneficiary pays the $100 deductible; we cover the 20-percent copay—and the member is subject to balance billing. Other benefits such as a 24-hour personal health adviser often are included in our plans.

The reason Medicare Select works is simple. Members are given incentives to use network providers whose practices are lower in cost and higher in quality than the norm. When beneficiaries stay in-network, significant savings accrue. Maximizing the potential of the supplemental market depends on allowing and even encouraging managed care plans to design Medicare Select alternatives that contain incentives to increase in-network utilization. This is the best possible use of private markets. The government maintains a role in oversight and funding, but saves money because of beneficiaries' purchasing choices and the private marketplace's downward pressure on cost and utilization.

The first step in Medicare reform, therefore, is to make Medicare Select permanent. The broader issue is Medicare's role as a purchaser of care. If Medicare is to provide coverage comparable to what is available to the rest of the population, substantial changes must be phased in.

Let me review a long-term approach and some practical short-term actions for beginning to get us there. Over the long term we should aim to phase in a Medicare program that will meet the following standards. Individuals should have a choice of qualified health plans, Medicare as a plan sponsor should set its payment level based on premium levels in the local market, paying some percentile of the premiums charged by health plans. And given the fiscal realities in Washington we recognize that payment, like contributions from large employers, will be constrained.

Over time beneficiaries would pay the difference between the premium of the plan they choose and the standard government payment level, paying more if they choose a high-priced plan and less if they choose a low-priced plan.

Now, there are an infinite array of programmatic and political issues to consider as part of such a major restructuring. While the philosophical debate is appealing to many, it is successful implementation that is important.

The practical reality is that you can't enact or implement long-term structural change all at once. If there is any lesson from the health care reform debate, it is that planned incremental change is the most viable course of action.

Let me outline a two-stage plan for legislative action. The first phase is to enact a package of incremental steps this year. First, make the Medicare Select program available to beneficiaries in all 50 States.

Second, revise the definition of health plans that can compete to serve the Medicare population. HMOs are no longer the only managed care entities with a proven track record. Many other managed care arrangements, including PPOs and point-of-service products, are effective and should be available to beneficiaries.

Third, begin to demonstrate and test implementation of three approaches that are critical to the future: These approaches include testing Medicare payment levels that are based on competitive premiums.

They also include testing methods to allow beneficiaries to compare the costs of the underlying Medicare fee-for-service system with the cost of competing health plans. This would require demonstrations in which the Medicare fee-for-service plan is a competing plan itself. Let it compete with the private sector.

Another approach is to test methods for making payments to employment-based retiree health plans so that retired individuals don't have to switch plans but can continue to get benefits in the plans they are accustomed to.

Finally, set up a rigorous monitoring process and prepare to change and change rapidly. If we are to proceed with structural change, meaningful change, we need to be able to make corrections as we move through time.

The second phase is harder to define because it depends on the findings in the first phase. In general, it would involve phasing in a more competitive Medicare pricing system based on the results of the demonstrations.

In addition, considerations should be given to implementation of payments for employment-based health plans, and further expansion of the definition of participating health plans.

Mr. Chairman, it is the combination of a long-term direction coupled with realistic annual implementation steps that will result in continuous improvement in the Medicare program. Blue Cross of California will be pleased to work with the committee as you pursue the difficult tasks that lay ahead.

I will be happy to answer any questions you might have.

[The prepared statement follows:]

TESTIMONY OF LEONARD D. SCHAEFFER
BLUE CROSS OF CALIFORNIA

Good morning, Mr. Chairman, members of the Subcommittee. My name is Leonard Schaeffer and I am chairman and CEO of Blue Cross of California (a non-profit public benefit corporation) and Chairman and CEO of WellPoint Health Networks, Inc. (a publicly-traded company). Our companies serve older Americans as a Medicare Risk Contractor, an authorized Medicare supplement/Medicare Select provider, and as a Medicare Intermediary.

Let me begin by thanking you for inviting me to share my thoughts on improving the federal Medicare program. My remarks reflect lessons I have learned from working in both the public and private health care arenas.

On the public sector side, I have served as the Administrator of the Health Care Financing Administration (HCFA) and as:

- Health, Education, and Welfare (HEW) Assistant Secretary for Management and Budget;
- Director of the Bureau of the Budget for the State of Illinois; and
- Deputy Director for Management, Illinois Department of Mental Health and Developmental Disabilities.

My private sector experience includes my current roles at Blue Cross and WellPoint and service as President of Group Health, Inc., a large staff model HMO in Minnesota.

Lessons Learned from the Public and Private Sectors

The most important lesson I have learned is that health care is a locally delivered and locally consumed service. This simple observation helped me to understand the frustrations I often encountered as a HCFA Administrator.

Large government institutions want stability, predictability, and control so they enact rules to standardize processes not just for government activities, but for the private sector as well. The problem is that if you are in the business of financing or delivering health services to diverse and rapidly changing populations you must be flexible enough to be responsive to varying consumer and provider demands.

A second observation is that there is a tendency to underestimate the ability of the public to make health care decisions And there is an even greater tendency to underestimate the desire and ability of older Americans to make good choices for themselves. Contrary to this belief, older Americans are among the most knowledgeable and informed consumers.

In looking at the future of Medicare, most of the discussions to date have focused on how Medicare can make better use of managed care as a purchaser of the Medicare benefit package.

That perspective is very important. You will hear a lot of very good testimony today on that subject because it makes sense to most of us in the health care system that Medicare should move rapidly from its anachronistic traditional fee-for-service model to today's managed care approach.

Based on my experience, however, I would suggest that it is also appropriate to view Medicare reform from the perspective of seniors as informed purchasers of health care. If we do so, we will begin to ask different questions that lead to new ways of achieving our goals of expanded choice and provider access, high quality of care, and lower costs.

Creating a More Competitive Supplemental Medicare Market

Viewing seniors as purchasers leads us to explore the "real" market in which seniors are making local choices about their health coverage based on local options. This real market is not Medicare alone, or just Medicare Risk HMOs, but the Medicare supplemental market (sometimes referred to as the "Medigap" market). This private market is a place where Medicare can take advantage of proven managed care models (including flexible PPOs and other arrangements) that lower costs, enhance quality, and expand access to providers beyond those that accept Medicare assignment.

Real savings accrue when managed care plans can design Medicare Select alternatives that contain incentives for beneficiaries to use selected provider networks for their supplemental and primary (i.e. Medicare) medical coverage.

In addition, managed care plans should be given the opportunity to perform the program safeguard activities of Medical Review and Provider Audit. These companies could then supplement or replace these activities with more industry typical pre-service utilization management, case management, and disease state management techniques. In a competitive market, these programs will be much more effective and lower supplemental premiums, while saving money for the Medicare program.

A Closer Look at the Supplemental Market

The vast majority of Medicare beneficiaries have supplemental coverage. Health plans have entered this market to compete for the opportunity to cover the growing costs that Medicare does not pay. Although Medicare is covering less every year, the competition in the supplemental market ensures that health plans find ways to control these cost and provide coverage at affordable rates.

It bears repeating that this is a real market-- millions of older Americans choosing to buy coverage with their hard-earned money. These are out-of-pocket premiums, not government subsidized payments. This market is not that much different than the under 65 individual market except that, like Medicare, it has been largely fee-for-service.

Only very recently, with the advent of the Medicare Select Demonstration, has the government begun to permit options for beneficiaries to join private health plans that compete to develop low-cost, high quality provider networks, incorporate managed care, enhance the benefits, and, as a result, lower beneficiary premiums for supplemental benefits.

Nationally, over 440,000 seniors have chosen Medicare Select as an alternative to other types of supplemental coverage. Purchasing a supplemental policy offered through managed care networks can save seniors 10 to 37 percent over traditional fee-for-service supplemental products. For individuals living on a fixed income, saving as much as $25 per month and $300 per year is significant.

The reason Medicare Select works is simple-- the provider networks that are central to the success of managed care plans include providers whose practices are demonstrably lower cost and higher quality than the norm. If the market is allowed to evolve, more and more managed care features will be employed, creating more savings, flexibility, and choice.

Our Experience in California Has Shown That:

- Medicare Select saves seniors money through premiums that are lower than traditional fee-for-service supplemental products.

- Medicare Select also saves the taxpayer money as well.

Medicare Select members benefit from having the best network providers linked together to create an efficient, coordinated system of care for delivering both their supplemental and primary medical coverage. These savings are passed on to the beneficiary and also to the federal government because these private market utilization changes spill over into the traditional Medicare market-- Medicare does not have to intervene. If you give this market a chance to work nationally, the federal government will save even more.

Analysis of BCC data on our population of Medicare supplement/Medicare Select members show that savings accrue to the government when seniors use in-network providers. Specifically, we have found that for 1993:

- The cost of medical services per admission for network providers was 20% lower than for non-network providers.

- The average length of stay for network providers was 50% lower than for non-network providers.

Our experience with Medicare Select indicates that 70% of services are rendered by network providers, 30% by non-network providers.

The federal government can thus use market forces that exist in the supplemental market to the advantage of the Medicare program. It is the best possible use of private markets-- the government's involvement is limited to plan certification, but the government saves money because of beneficiaries' purchasing choices and the private marketplace's downward pressure on cost and utilization.

The first step of Medicare reform, therefore, is to make Medicare Select permanent.

BCC's Medicare Select Products -- One Company's Example

Blue Cross of California (BBC) provides services to seniors through multiple supplemental options. About half our senior membership remain today in pre-OBRA, non-standard plans and in post-OBRA standard supplemental plans. Between our 3 Medicare Select products, we serve nearly 90,000 members, with 24,000 members enrolling in the last twelve months.

These products provide senior members with access to:

- Nearly 40,000 physicians (half of which are specialists) with no balanced billing to beneficiaries;

- Providers beyond those that accept Medicare assignment.

- Carefully selected providers that meet our quality and credentialing standards;

- Physician management of episode of care, including appropriate utilization and specialty referral,

- Formal administrative, clinical, and peer review of the quality and appropriateness of care;

- Continual improvement of network performance resulting from detailed analysis of more than 30 million claims annually;
- Enhanced benefits that include outpatient prescription drugs, and a range of home health, home support and custodial services; and
- State-of-the-art fraud and abuse detection and profiling.

Our satisfaction surveys for 1994 demonstrated that, overall, our senior members were highly satisfied. Our Medicare Select members were even more satisfied than members in our other supplemental plans.

Consequences of Ending Medicare Select

As you are aware, Medicare Select expires June 30, 1995, effectively freezing enrollment. Clearly this would negatively impact hundreds of thousands of seniors nationally who would see their premiums dramatically increase because keeping the program affordable depends on continually attracting new members. It would also eliminate an important, successful, and very flexible managed care option at a time when seniors are demanding more choices, not less.

As these hearings indicate, there is intense interest in private sector innovations with potential to improve the Medicare program. Medicare Select is an example of such innovation-- applying managed care principles to supplemental coverage-- which has proven successful. Let's extend the program now. Tying the continuation of Medicare Select to the more lengthy process of comprehensive reform of Medicare would threaten the future of supplemental coverage built around choice.

Concerns with Recent Proposals to Improve Medicare Select

The recent RTI report contained some criticism of the Medicare Select program. While I do not seek to minimize such criticism, the program was evaluated in its infancy and RTI itself cautions that "the results are in many ways preliminary." The program has evolved positively and many of the RTI findings no longer apply. For example, our Medicare Select options are now in compliance with NAIC standard plan designs. We have also been approved to market a unique "second generation" Medicare Select product offering even better benefits.

The potential rush to "federalization" of a very young program is a concern. State regulators are better equipped to oversee their respective managed care markets in a way that protects consumers, but also fosters the innovation necessary to serve different markets.

Applying the Section 1876 provisions for Medicare risk contractors to a program providing supplemental coverage, not primary medical coverage, is a second concern. Overlaying these provisions would be duplicative in some areas and inappropriate in others, creating conflict and confusion. A better approach is to develop provisions specific to Medicare Select. Already the Blue Cross/Blue Shield Association has delineated four appropriate areas on which to concentrate:

- Explanation of restrictions/procedures for out-of-network and out-of-area coverage
- Accessibility of providers included in the network

- Quality assurance to ensure availability of high quality care within the network
- Grievance procedures pertaining to out-of-network coverage in emergencies or during travel to areas not served by the network

Conclusion

The first priority with respect to Medicare Select should be kept simple-- make the program permanent and available in all 50 states. This is the thrust of the Johnson (H.R.483) and Chafee bills (S.198). Once seniors can rest easy that this popular program is safe, we can assess potential ways to improve it. Health plans offering this managed care option are certainly willing -- even eager-- to work with Congress and HCFA to make the program better.

Chairman THOMAS. Thank you very much.

Rather than begin the questioning at this point, can we go vote and come back? We will be back as soon as we can.

The committee stands in recess until we return from the vote.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

The gentleman from Washington may inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to ask a couple questions. I suppose it is perhaps a tad unfair, but you know this is a great game here; you were both at HCFA for a long time. Why when you were there didn't you institute this managed care business? Because you know and I know that this Communist plot started in the Northwest in 1947, as Group Health of Washington. The doctors were so reviled that they couldn't even get into the medical association, they had to sue, and it went all the way to the State supreme court. So this is not a new idea of managed care, and——

Dr. ROPER. Sure, I will be happy to answer your question.

I don't want to put too fine a point on it, but in the mid and late eighties, the latter part of the eighties when we were pushing this, the makeup of the Congress was different than it is today. We pursued an agenda that fell on deaf ears before this committee.

Mr. MCDERMOTT. You are saying at that time Democrats resisted socialism?

Dr. ROPER. No, sir.

Mr. MCDERMOTT. Is that what you are saying? And now the Republicans are throwing themselves into it?

Dr. ROPER. The leadership of the committee resisted changing the program in the constructive ways that I and others will argue for before you today; that is, removing the unnecessary statutory and then regulatory impediments to making this happen.

Mr. MCDERMOTT. Give me the arguments they gave. What was their argument?

Dr. ROPER. Essentially that managed care is somehow a sinister force that is going to do bad things to senior citizens, when in fact the senior citizens that we do have enrolled in managed care plans tell us and others that they are very satisfied, very happy to be there.

Mr. MCDERMOTT. Mr. Schaeffer, you have had other experiences besides your present position, actually running a big HMO. What is your belief, or do you have any belief that there should be any limitation on the profit that people take out of the health care system? You ran a not-for-profit.

Mr. SCHAEFFER. Right. Well, I think the problem in health care is that doing what we are being asked to do is very, very difficult. There is a lot of good health policy work that has been done in this city and others that talks about what ought to happen to improve the health care system in terms of cost and accessibility, and it turns out that it is very, very difficult to do, and what has happened over time is that organizations that have been able to do that have attracted, you know, investors' interest. So there are people that now see that bringing a lower cost, higher quality product to the market has value, and so you have for-profit players in this business.

I think the market will control the profitability because you have to be competitive. And, you know, companies that are excessively profitable, whatever that means, probably won't be able to compete, but companies that are able to control costs and to assure accessibility will do very well.

Mr. McDermott. Are you suggesting that the company that is making 20-, 30-percent profit and advertising it in their promotional material for selling stock are short lived, that they are going to be short lived, or are you saying that they are grabbing and running? How do you explain that?

Mr. Schaeffer. I am saying neither. There is irony in making me the poster child for for-profit companies, but, you know, it has been——

Mr. McDermott. You mean you haven't been profitable?

Mr. Schaeffer. No, meaning that I have not been in that situation for very long. But——

Mr. McDermott. That is why I got you instead of Mr. Roper.

Mr. Schaeffer. I think if you look back, when I was in HCFA the issue was for-profit hospitals, were they OK or not OK, and I think everyone looked at them very carefully and found that, you know, the quality and the accessibility was there for most of them, and that if they could compete successfully with a not-for-profit hospital, there was probably some added value, and I think that is still the case.

The difficulty is that today to really be an effective managed care company takes technology as well as people, and investors I think have found ways to gather excellent technology and excellent people, make a big investment, and see the result. It is very difficult.

Mr. McDermott. Let me ask you a question before my time runs away. End-stage renal disease—I asked Mr. Vladeck about it—do you think your company is ready to take those people into your health care system?

Mr. Schaeffer. It depends on the rules under which——

Mr. McDermott. You offer a policy.

Mr. Schaeffer. Unlike some of the comments that were made earlier here about the private sector not covering people, in California we have a government program that was specifically set up for so-called uninsurable individuals, and——

Mr. McDermott. What is the premium?

Mr. Schaeffer. I don't know, but I can bring it. It is higher than it is for other people because the costs obviously are higher.

[The following was subsequently received:]

Blue Cross
of California

California Major Risk Medical Insurance Program: Access to Private Health Plans for Underserved Californians

The Major Risk Medical Insurance Program (MRMIP) offers affordable state-subsidized health coverage to individuals unable to secure adequate private coverage due to their health status. The program is funded by an annual allocation of $30 million in Proposition 99 tobacco tax funds.

Program Design

Choice of benefits plus subscriber cost-sharing mean affordable premiums.

- Comprehensive benefits including preventive, primary care, maternity care, preventive care for children, mental health care, and emergency care.

- Out-of-pocket expense in limited to $2,000 per member or $3,000 per family unit per calendar year, this includes $500 deductible and co-insurance. Program benefit is $50,000 annual maximum and $500,000 lifetime maximum.

Partnership: state provides subsidy, while health plans assume underwriting risk.

- Subscribers pay a premium equal to 125% of the carrier's standard average individual rate. The state subsidizes the balance of the set premium to the carrier. BCC is the only health plan on full risk for this program.

Principles of managed competition work to create a successful, growing program.

- Subscribers choose from seven competing managed care health plans including both PPOs and HMOs.

Program Statistics (June, 1995)

- 19,235 enrollees
- 43,439 applications
- 1,000 persons on waiting list

Blue Cross of California (BCC) Participation

- BCC offers an interim plan for those on the MRMIP waiting list; currently 330 enrollees.

- BCC is the program administrator for the State as well as a participating health plan offering a PPO product.

- BCC covers and solely underwrites the health risk for nearly 70% of total enrollees.

- BCC consistently offers lowest rates regardless of geographic region.

June 13, 1995

California Major Risk Medical Insurance Program

Area 1

Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, Yolo.

	Subscriber Only				Subscriber + 1 Dependent			
Age	BC	BS	KPNC[1]	PM[2]	BC	BS	KPNC[1]	PM[2]
<15	$71.25	$93.00	$72.27	$140.52	$126.25	$171.00	$185.45	$316.79
15-29	$92.50	$93.00	$ 89.51	$149.51	$168.75	$171.00	$185.45	$329.30
30-34	$113.75	$128.00	$111.82	$162.92	$205.00	$239.00	$218.18	$346.05
35-39	$121.25	$128.00	$120.00	$171.08	$220.00	$239.00	$229.09	$372.44
40-44	$123.75	$136.00	$124.09	$214.45	$228.75	$266.00	$235.90	$427.46
45-49	$138.75	$136.00	$129.54	$266.52	$255.00	$266.00	$249.54	$505.88
50-54	$165.00	$193.00	$154.09	$325.95	$301.25	$383.00	$298.63	$616.00
55-59	$188.75	$193.00	$190.91	$459.70	$342.50	$383.00	$368.17	$852.18
60-64	$223.75	$241.00	$216.81	$614.21	$401.25	$483.00	$426.81	$1,132.79
65-69	$250.00	$298.00	$242.72	$703.37	$450.00	$595.00	$475.90	$1,313.89
70-74	$263.75	$358.00	$256.36	$866.81	$473.75	$715.00	$503.17	$1,648.08
75+	$278.75	$424.00	$271.36	$1,074.82	$501.25	$846.00	$533.17	$2,039.99

[1] Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Amador—95640 and 95669,
El Dorado—95613-14, 95619, 95623, 95633-35, 95643, 95651, 95664, 95667, 95672, 95682, and 95727;
Kings—93230;
Placer—95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95746-47, and 95765;
Sutter—95622, 95659, 95668, and 95674;
Tulare—93618, 93666, and 93673;
Yolo—95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, and 95798-99;
Yuba—95692, 95903, and 95961.

[2] PM Group available **only** in El Dorado, Kings, Mendocino, Placer, and Tulare Counties.

Area 2

Counties: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus.

	Subscriber Only					Subscriber + 1 Dependent				
Age	BC	BS	KPNC[3]	MC[4]	PM[5]	BC	BS	KPNC[3]	MC[4]	PM[5]
<15	$72.50	$93.00	$73.63	$94.99	$144.17	$132.50	$179.00	$189.54	$202.53	$325.37
15-29	$92.50	$93.00	$ 91.36	$202.03	$153.38	$175.00	$179.00	$189.54	$430.72	$338.23
30-34	$113.75	$128.00	$107.73	$215.31	$167.15	$208.75	$239.00	$211.36	$459.07	$355.41
35-39	$122.50	$128.00	$122.72	$219.69	$175.51	$226.25	$239.00	$233.18	$468.09	$382.52
40-44	$130.00	$145.00	$128.18	$242.77	$220.03	$240.00	$283.00	$241.36	$517.59	$438.98
45-49	$150.00	$145.00	$140.45	$291.31	$273.45	$276.25	$283.00	$271.36	$621.10	$519.51
50-54	$183.75	$218.00	$169.09	$365.20	$334.43	$332.50	$423.00	$328.63	$778.64	$632.59
55-59	$210.00	$218.00	$210.00	$500.29	$471.61	$376.25	$423.00	$407.72	$1,066.68	$875.11
60-64	$236.75	$255.00	$225.00	$690.28	$630.15	$422.50	$500.00	$441.81	$1,471.74	$1,163.27
65-69	$263.75	$314.00	$249.54	$882.38	$721.60	$472.50	$616.00	$492.26	$1,881.32	$1,349.25
70-74	$278.75	$379.00	$264.54	$1,072.37	$889.29	$497.50	$741.00	$520.90	$2,286.39	$1,692.47
75+	$295.00	$448.00	$280.90	$1,378.45	$1,102.70	$527.50	$878.00	$550.90	$2,939.00	$2,094.94

[3] Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Fresno—93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-94, and 93844-88;
Madera—93637-39 and 93645;
Napa—94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, and 94599;
Sacramento—All zip codes;
San Joaquin—All zip codes;
Solano—All zip codes;
Sonoma—94922-23, 94927-28, 94931, 94951-55, 94972, 94975, 95401-09, 95413, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492.

[4] Maxicare available **only** to residents in these zip codes in these counties:
Fresno—93602-09, 93611-13, 93616, 93621-33, 93641, 93646, 93648-52, 93654-62, 93667-68, and 93675-93888;
Santa Cruz—95001, 95003, 95005-07, 95010, 95017-19, 95060-67, and 95073-77
Solano—94510, 94512, 94533, 94535, 94571, 94585, and 94589-92

[5] PM Group available **only** in Fresno, Imperial, Kern, Madera, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus Counties.

Monthly Rates

Subscriber & 2 + Dependents			
BC	BS	KPNC[1]	PM[2]
$182.50	$276.00	$264.54	$472.03
$280.00	$276.00	$264.54	$484.54
$331.25	$353.00	$297.27	$604.99
$348.75	$353.00	$319.08	$679.58
$352.50	$363.00	$323.18	$771.56
$376.25	$363.00	$331.36	$848.39
$420.00	$461.00	$370.90	$934.44
$460.00	$461.00	$429.54	$1,098.36
$510.00	$533.00	$471.81	$1,288.19
$571.25	$645.00	$526.35	$1,469.34
$601.25	$765.00	$557.72	$1,803.63
$637.50	$896.00	$590.44	$2,195.63

Subscriber & 2 + Dependents				
BC	BS	KPNC[3]	MC[4]	PM[5]
$195.00	$283.00	$275.45	$289.38	$485.02
$291.25	$283.00	$275.45	$615.40	$497.86
$346.25	$368.00	$313.63	$655.91	$621.67
$366.25	$368.00	$321.81	$668.77	$698.34
$367.50	$376.00	$328.63	$739.51	$792.81
$395.00	$376.00	$342.27	$744.25	$871.76
$447.50	$493.00	$398.17	$1,112.48	$960.02
$486.25	$493.00	$479.99	$1,524.02	$1,128.28
$523.75	$543.00	$492.26	$2,102.77	$1,323.13
$586.25	$659.00	$548.17	$2,687.94	$1,509.17
$617.50	$784.00	$580.90	$3,266.68	$1,852.49
$653.75	$920.00	$614.99	$4,199.12	$2,255.07

BC = Blue Cross BS = Blue Shield CC = Contra Costa Health Plan KPNC = Kaiser Permanente Northern California
KPSC = Kaiser Permanente Southern California MC = Maxicare PM = PM Group

Mr. McDermott. So if we gave you the ability to segment into those who are high cost or high users and left you with the other people, you could handle it as long as we gave you the ability to segment?

Mr. Schaeffer. We take all comers in California. We have a guarantee issue program that takes anyone.

Mr. McDermott. It sounds like you have a program specifically for high-cost people.

Mr. Schaeffer. It was started as a government program and we asked permission to take it on as a private product, and the government ran out of money to fund the program, and we now make it available as a private product from our company.

Mr. McDermott. I would love to see the information. I think the committee would like to see that.

[The following was subsequently received:]

GUARANTEEING ACCESS TO HEALTH COVERAGE
Blue Cross of California's Guaranteed Coverage Program

D. Mark Weinberg
Executive Vice President
Blue Cross of California

Since Blue Cross of California announced its Guaranteed Coverage Program last year, roughly 151,000 individuals have enrolled. The Guaranteed Coverage Program provides health coverage to any uninsured applicant, regardless of health condition. Depending on the individual's health condition, Blue Cross places applicants into one of four levels of coverage. Benefits and premiums for each level of coverage vary by age, region and severity of health condition.

Some 13,200 previously uninsured members accepted into two of the four levels of coverage probably would have been denied coverage by other carriers since no other health plan or insurer in the State offers a program remotely similar to this one. Industrywide, between 10 and 15 percent of individual applicants are denied health benefits. Not so at Blue Cross. No uninsured individual applicants are denied.

The program's design is simple: different levels of coverage and premiums for different levels of health conditions. Level I provides the variety of both PPO and HMO managed care plans currently offered by Blue Cross to individual purchasers. Level IA, costing 20 percent more than Level I coverage, but providing the same broad choice of plans as Level I, covers individuals with health conditions such as ulcers and skin cancer. Level II provides two plan choices with higher patient out-of-pocket cost requirements to customers with higher medical risks, for example, diabetes and hypertension, and costs approximately 50 percent more than similar Level I plans. Level III offers a single plan option with higher patient out-of-pocket cost requirements and is designed for those uninsured individuals with severe chronic and acute medical conditions who have been declined coverage in the past by another health plan. This plan costs about 50 percent more than the comparable Level II plan.

The company has determined that since the program's inception, 91.2 percent were accepted into Level I, 6 percent for the new Level IA, with the remaining 4 percent divided between Levels II and III. None have been declined. The bottom line here is that Blue Cross took thousands of individuals with health conditions and provided them with the most affordable level of coverage and did not turn away any uninsured individual applicant.

Other health plans providing coverage for individuals might accept members in Blue Cross' "Level I" plans. Those with health conditions would have few or no alternatives. California law prohibits carriers from excluding -- or waiving -- health conditions from their members' coverage. Thus, most carriers usually reject, for example, uninsured diabetic or asthmatic individuals applying for coverage. Under the Guaranteed Coverage Program, Blue Cross covers these uninsured applicants. Individuals in Level III have very serious health conditions such as cancer or AIDS and are uninsurable using a traditional approach. Level III is the only such plan offered by a private carrier in this State and is designed to complement California's Major Risk Medical Insurance Program (MRMIP), a state-funded pool for high-risk individuals, for which there is often a waiting list.

Under California's Major Risk Medical Insurance Program (MRMIP), once a level III member has satisfied a typical waiting list process, the state adds a subsidy to enrollees worth about 50 percent of the premium for a limited number of Californians. The government has a fixed amount of annual funds for MRMIP. When the money is gone, enrollment in MRMIP ends.

Before the Guaranteed Coverage Program, there were no options for those on MRMIP's waiting list. Blue Cross is the only health plan to assume 100 percent of the risk for individuals before they finally get into MRMIP. Blue Cross also offers health coverage under MRMIP, making them one of the few carriers to assume all of the risk for these individuals. Interestingly, over 70 percent of MRMIP enrollees chose Blue Cross for their coverage. Under this unique approach to guaranteed coverage, Blue Cross' responsibility does not change once the majority of individuals move into MRMIP. The Guaranteed Coverage Program covers them before MRMIP and covers most of them when they are enrolled in MRMIP.

This innovative program proves that health plans can guarantee access to health care for all individuals, regardless of their health status. The key, however, is that the carrier must have the ingenuity to skillfully manage health care while ensuring its quality. To date, Blue Cross continues to be the only health plan or insurer in California to offer such a program demonstrating the company's expertise in managing health care. And thousands of Californians have turned to Blue Cross as a result making this company the largest individual carrier in the nation.

Guaranteed Coverage Program Simplified

Level I - Level I Plus 20% - Level II - Level III

Individuals **INSURED or UNINSURED**		***Only for those wtihout health insurance coverage within the past 30 days of the date of application***	***Available only to Individuals not eligible for Level I or II***
Personal Prudent Buyer *Level I*	***Personal Prudent Buyer*** *Level I Plus 20%*	***Personal Prudent Buyer*** *Level II*	*Level III*
Standard plans you have always sold.	Based on Medical History, 20% rate up of Level I premium. Basic, Classic, & CaliforniaCare (Not available on Choice). For insureds or uninsureds.	Based on Medical History, applicant may be placed in this level. $500 or %1000 deductibles	For serious medical conditions. In conjunction with the state MRMIP (Major Risk Medical Insurance Plan). If there is waiting list, we will issue this plan while subscriber is on waiting list.
Basic (Hospital) Plan $2,000 deductible ➡ Classic Plans 250, 500, 1000, 2000 ➡ Choice Plans 500, 1000 ➡ CaliforniaCare (HMO) ➡	Basic (Hospital) Plan $2,000 deductible Classic Plans 250, 500, 1000, 2000 Classic Plan 500, 1000 CaliforniaCare (HMO)	• $500 or $1000 annual deductible • 80/20%coinsurance (subscriber) • $10,000 subscriber yearly out-of-pocket stop loss • $5,000,000 lifetime limit Applicants originally applying for 250-500 deductible will be issued 500 deductible Level II. Applicants originally applying for 1000-2000 deductible will be issued 1000 deductible Level II.	• $500 annual deductible • 80/20% coinsurance • $2,000 subscriber yearly out-of-pocket stop loss • $50,000 annual limit • $500,000 lifetime limit • Must be eligible for MRMIP program • Subscriber pays full premium (including the amount the state would have subsidized, if subscriber had enrolled immediately into MRMIP)

Please see brochure and certificate for complete details.

Chairman THOMAS. The gentleman's time has expired, but you are on to something here, and actually I was going to talk about it. I am glad you brought it up.

The contemplating of the unknown in terms of this adverse risk selection problem when people of their own choice walk out of a system has actually been experienced in California where we had a State risk pool. The State refused to fund it because of all of the allegations and the risk. It was almost collapsing. The private sector said, to their credit, "We will take it on," and they have done just that. They have structured—there is no question it is slightly higher, but it is not the scenario that was potentially spelled out earlier. It is interesting. I don't know if any other States have been involved in it.

[The following was subsequently received:]

STATE HIGH-RISK HEALTH INSURANCE POOLS

	Year Oper	1993 Enrollees	Premium Cap*	Funding Source
Alaska	1993	113	200%	Assessment
California	1991	16,785	125%	Tobacco Tax
Colorado	1992	2,046	150-175%	Tax Surcharge
Connecticut	1976	1,610	125–150%	Assessment
Florida	1983	3,476	200-300%	Assessment
Georgia	not	funded	125-150%	Gen Revenue
Illinois	1989	4,693	135%	Gen Revenue
Indiana	1982	4,924	150%	Assessment
Iowa	1987	1,753	150%	Assessment
Kansas	1993	343	NA	Assessment
Louisiana	1992	228	150-200%	Patient Charge
Minnesota	1976	35,296	125%	Assessment
Mississippi	1992	365	150-175%	Assessment
Missouri	1992	987	150-200%	Assessment
Montana	1987	289	150-400%	Assessment
Nebraska	1986	3,282	135%	Assessment
New Mexico	1988	1,294	150%	Assessment
N. Dakota	1982	1,538	135%	Assessment
Oregon	1990	4,091	150%	Assessment
S. Carolina	1990	1,437	200-300%	Assessment
S. Dakota	1994	NA	150%	Assessment
Tennessee	1987	3,411	150%	GR + Assess
Texas	not	funded	150%	Assessment
Utah	1991	681	150%	Gen Revenue
Washington	1988	4,387	150%	Assessment
Wisconsin	1981	12,045	150%	Assessment
Wyoming	1991	206	150-200%	Assessment

* Refers to state-imposed limits that cap premiums at no more than a fixed percentage above the standard premium charged by private carriers to low-risk individuals in the state.

Source: Blue Cross and Blue Shield Associaiton and Communicating for Agriculture, 1994

Mr. SCHAEFFER. Other States have other versions.

Let me just briefly tell you about an anecdote that happened. The State had a very limited budget. Only so many people could get in. There was a long waiting list. We were involved in administering the program. We saw how it worked for a couple of years, and we developed a product for people who were on the waiting list. And so they are covered by a private insurance plan that is very consistent with the government plan until they can get into the program, and oddly enough, as a result, the government has now seen no need to expand the funding for the program. But it is there.

Chairman THOMAS. How long has this been going on?

Mr. SCHAEFFER. Mr. Chairman, I would say 2 years, maybe 3. I don't remember. I can get it for you.

[The following was subsequently received:]

California's major risk medical insurance program (MRMIP) has been in place since 1989. Blue Cross of California's guaranteed issue program has been in place since 1992.

Chairman THOMAS. So in other people's terminology, this is a blip? We don't know if it is going to work?

Mr. MCDERMOTT. The one thing he hasn't told us, though, is the premium. Until we see what the premium is, we will have to talk about how many people could take advantage of it.

Chairman THOMAS. Understood.

Mr. Christensen.

Mr. CHRISTENSEN. Mr. Schaeffer, your testimony indicates that your program is saving the Federal Government money, yet we just heard Mr. Vladeck testify that most Medicare Select programs are just discount arrangements, they are not really managed care.

Can you explain to the committee whether your program can be structured to save money, is saving money, will continue to save money, or is what Mr. Vladeck said the more accurate statement?

Mr. SCHAEFFER. Well, I have talked to Bruce about this on other occasions, and I think he said in his testimony that in California it does work, and so I hope there is no contention over whether we save money or not. I believe that is accepted. I think the question is why. I like to think it is brilliant leadership, but I think it is a little more complex than that.

Basically we have a very—or a more mature and a very hotly competitive environment, and if you want to look at sort of the way HMOs and managed care has evolved there are some theories about what happens in the first stage, second stage, and third stage. We are at that third stage.

You cannot be successful in California on the basis of discounts alone. That just isn't enough. You have to go through a process of identifying the low-cost, high-quality providers, getting them in a network, developing a business relationship with them where you are channeling patients, and in return they are giving you appropriate assurances about cost per unit and number of units, and when you have built a network like that, when you then take Medicare Select and offer Medicare Select beneficiaries the opportunity to go in-network, they get the benefit of the lower utilization in that network, and that is what has happened in California, and clearly, I believe—I can't demonstrate it—but I believe that as other parts of the country, you know, mature in terms of managed care plans that similar advantages would occur there.

You might ask Bill. I think he has a national plan.

Dr. ROPER. Medicare Select is a good idea. We support making it permanent and nationwide. I would just urge you all to please just do that, but that is not the future of the Medicare program, and get on to the much more basic considerations.

Mr. SCHAEFFER. I think Bill is making an important point. Medicare Select is an easy first step, and it will save money, but there are ways to save lots more money after that, and I think we are just a little surprised, you know.

Dr. ROPER. I would urge you not to be distracted about that.

Mr. CHRISTENSEN. I think that is what this committee wants to hear in more detail, those ideas that are going to save money and continue to implement those programs that are currently saving this country money.

I have great respect for the gentleman from Washington but I also vigorously debate many of his viewpoints. It makes it sound like something is wrong with the word "profit." You know, profit is one of the components of capitalism. There is nothing wrong with profit. If the market allows a 20- or 30-percent profit, that is what I believe is the correct approach. I believe that gives opportunity for another company to come in and to operate at a 10-percent profit and to beat that other company.

I know that my colleague from Washington may disagree with me on how we go about insuring this country, but I do believe that is one of the principles that this country was founded on.

Would the gentleman want to respond at all?

Mr. MCDERMOTT. Oh, thank you.

Chairman THOMAS. He doesn't need prompting.

Mr. MCDERMOTT. The debate is not over profit. The debate is over how much and what you have to do to get the profit, and whether or not you give the same quality of care.

The question really revolves around the whole question of the quality of care. If you can take the same dollar that Medicare is giving 98 percent out in payments for health care, if you can take that and give those same benefits and take away 30 cents, 30-percent profit, that is pretty amazing. I would like to know how you do it.

Mr. CHRISTENSEN. Would the Chairman allow me to ask one more question in my short 20 seconds remaining?

Chairman THOMAS. Certainly.

Mr. CHRISTENSEN. On that basis, Dr. Roper, could you respond? Is that really the true efficiency of the Medicare system?

Dr. ROPER. Sure. The point I would strain to make in response to both of you is what managed care does is not simply go in and deny benefits. I think that is the myth that has arisen by the critics of managed care. If there is any population in America that deserves the benefits, the preventive services, the integrated and coordinated care, it is the Medicare population and the Medicaid population, I would hasten to add.

Somehow or another we have lost sight of the fact that senior citizens—like my dad, Richard Roper, 78 years old, in Birmingham—need the benefits of a system that helps them through a complicated, difficult time in their lives, and managed care companies offer that to the Medicare population if we will just allow it to happen. Unfortunately, some have tried to turn things around to say that the Yellow-Pages method of organizing the health care system, which is what fee-for-service is all about, is a fond memory that we should recall. But that is just not the case.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I thank you both for your testimony and certainly don't think for 1 minute that we think we will have solved all the problems by extending Medicare Select permanently. We do see that as simply a step that can be taken immediately, we can let the market begin to develop, we can encourage managed care plans, and we will have a better opportunity and we will have stimulated a development in the private sector that will give seniors more choice once we figure out how to give them that buying power in the market.

But, Mr. Schaeffer, I wanted to ask you two things because, frankly, in my conversations with Mr. Vladeck it was clear to me that his concern about Medicare Select is that we don't regulate it enough.

Now, I did try to point out in my questioning what Federal and State regulations are in place, but would you comment for the record both on the RTI study which raises some questions about the Medicare Select program and about the proposal to apply the section 1876 provisions for Medicare risk contractors to the Medicare Select program, which I think is what the administration is under pressure to try to do either on their own initiative or as a result of interest by Members of Congress.

Mr. SCHAEFFER. The RTI study, that was done pretty early, and I think the data is not current, and I think at least in regard to California there really were not, I thought, many serious concerns other than the design of a plan. And when we understood what the concerns were, we immediately went back in and got the design change, and we are now to my knowledge completely copacetic.

I would say, though, that more regulation is probably not what Medicare needs. I mean, generically, and this is just a nice little example where we thought we were in compliance and nobody said we weren't until somebody came in and went through all the Mickey Mouse, but we can live and I think ought to live in a system that says the government has a right to make sure that no one is abused.

I think the concern is if government begins with the assumption that all the players are abusers and that everything has to be regulated, it just gets to be very cumbersome, and a great deal of time is spent on things that don't involve helping people, and I think that is what the program is all about.

In terms of section 1876, you know, I think that that was designed for one purpose, some of the ideas in there are fine, but we ought to go through them one by one and see if they really apply to Medicare Select. Medicare Select is not Medicare risk, it is very easy for seniors to understand, it has all the protections in it of the basic Medicare program. And I would question, as I said in my testimony, the federalization of something that is quite easy to understand and very attractive to seniors. I mean, they get it. This is not a tough program, and because they can go out-of-network, they feel good about it.

Now, they typically end up staying in-network. Our statistics are 70 percent are delivered in-network because we think we choose good network providers, but the savings just accrue. We are not bringing in people from left field who the local seniors don't know.

This is a pretty straightforward extension of Medicare. It saves money, it makes people feel good, it brings in the initial managed care techniques, and, as you have said, Mrs. Johnson, I would like to personally thank you for the battles last year, you know, there are a lot of people who depend on this.

We ought to do it and go. This is not an argument I can understand.

Mrs. JOHNSON. I do think also your testimony was very helpful in documenting the savings in the cost of providing medical care per admission for network providers—20 percent lower than for nonnetwork providers, length of stay down 50 percent.

And the point you made further, which I am not sure you had time to enlarge on, was the indirect effect of this on Medicare costs. Medicare is actually saving money because of these programs where they are well developed.

Mr. SCHAEFFER. Yes. I think it saves money in two ways. One, Medicare Select is immediate. That is a Medicare eligible, but I think that there is a halo effect of managed care, and we see it in California. It is very difficult for a provider to have two kinds of practice patterns. There are very few places you can shift the cost to anymore. We have a fairly sophisticated system and others do as well to track provider behavior. So as the health care system at large becomes more accountable, I think Medicare benefits, and that is to the good.

Mrs. JOHNSON. We do have to go vote, but I do want to thank you both very much for your testimony.

And, Dr. Roper, your comments about the initial voucher and what sum it can be based on and how we could accommodate it, it looks to me like we could do that over a rather short period of time with a fair degree of accuracy. Would you agree with that?

Dr. ROPER. The pricing mechanism can be improved. We need to put the best people together and make it work, yes.

Mrs. JOHNSON. And you would see once we tried to set the price from Washington, once there were a number of providers in the market, we could set the price based on market and competition.

Dr. ROPER. Currently we have the AAPCC methodology, which, when I was HCFA administrator, I appointed a task force 10 years ago to fix the AAPCC. You heard Bruce say he did the same thing. It has problems inherent in it and until we change it fundamentally, we will still have those problems.

It can be made better and ought to be for a year or two, but once there are enough competing plans in a market, put it out for bid, and then set the price based on the bids.

Mrs. JOHNSON. Thank you very much. I appreciate it.

Chairman THOMAS. Let me follow that on with the average adjusted per capita cost mechanism. Since it is tied to the old fee-for-service, in the timelines and the geography and the rest of it, it isn't a very good tool, but in your estimation I want to understand what you are saying. Would it be worthwhile investing time and attempting to modify it to provide that walkover comparison. Or, would you prefer not spending time on it and moving toward some kind of a blended profile?

Dr. ROPER. There are some straightforward things that could be done immediately. Instead of pricing by county, you could expand it to metropolitan statistical areas, some other steps like that, which people have suggested, deserve being done.

Chairman THOMAS. To me that is the key. We have been using the concept Medicheck, the idea of providing that funding, and the actuarial comparison for the walkover is the key to it. It is just amazing to me that we are carrying on apparently this fight over the extension of Medicare Select. This should be a given and we must-—and we are—move on to these larger questions.

When you look at those areas where Medicare Select has been popular, irony of ironies, it overlays where managed care is popular. Over the next several years we are going to have a significant number of people moving into Medicare who are coming from a workplace experience with managed care on programs that apparently were good and workable. I am just scared to death that we are going to set up all kinds of bureaucratic structures. If we allow them to just walk over into a structure for Medicare, you are going to get the same comfort level, but we have got administrators who want to stop that normal transition and set up a highly bureaucratic threshold.

Dr. ROPER. I agree with you. Can I just add one thing. I know you want to go and Len wants to say something.

Chairman THOMAS. I don't want to go, but I have to.

Dr. ROPER. My concern is given the studies that have been done on old data which say that in some cases the AAPCC is too high, you are going to come under pressure from people to say, Let's squeeze down on the managed care side of Medicare. If you do that, it will have just the opposite effect that you are seeking. It will make it less likely that you will ever be able to get Medicare out of the old style fee-for-service and into managed care.

Chairman THOMAS. It just seems to me at this stage since we are not comfortable, we can continue to try to adjust a formula which is to look ahead. But to settle this argument of whether or not these changes are blips or not, why don't we tie in a 1-year look back in terms of the real marketplace and march the two together and take whichever is less, which will move us forward in that structure. That is the kind of approach we are thinking about to get this process moving.

Mr. SCHAEFFER. Mr. Thomas, I think the point about the employment-based plans is very important, and you are increasingly seeing people sophisticated both about managed care and deciding they don't want managed care, and if we could have a system that would allow people to continue with what they have now with the government putting in, you know its appropriate level of payment, whatever that would be, I think you would find an awful lot of happy seniors because that makes sense to them. And this artificial break, some suggestions of a 1-day open enrollment, I mean, we are talking about a logistical nightmare that I just think we ought to rethink in terms of how people really live and what is a logical expectation.

Chairman THOMAS. I want to thank the panel. I want to assure you that the idea of trying to define what we ought to do, by the worst case scenario, will not drive us. They tried to do it with proposition 13, property tax changes in California.

If we are going to have to reduce it, we will close the library. On the SSI disabled, it isn't the alcoholics and the drug addicts, it is this poor unfortunate individual who has been on it for 10 years, they are the ones who are going to lose it. If we allow ourselves to be defined by end-stage renal disease, therefore we can't go forward with the significant changes, we really don't understand what this process is about. It is going to be fun determining who is leading whom in this process. And frankly I think the private sector on the long-term trend is way ahead of us and we have got to latch on.

I can't stay. You can talk into the mike for the record, but I can't miss a vote. We have a lot of them. I want to thank you.

This is not the termination of this discussion. We are looking for help to create the yardstick or the measure so folks can take that Medicheck and walk over into that other system, so we appreciate your testimony.

We will continue the hearing after the vote. The subcommittee is temporarily recessed.

[Recess.]

Chairman THOMAS. The subcommittee will come to order once again.

The next single panel, Ms. Shikles, who is the Assistant Comptroller General for the General Accounting Office.

Ms. Shikles, your written testimony will be made a part of the record, and you may proceed for 5 minutes in any way you feel would be helpful to the subcommittee.

STATEMENT OF JANET L. SHIKLES, ASSISTANT COMPTROLLER GENERAL, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. SHIKLES. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss options for expanding managed care under the Medicare program.

The current Medicare HMO option, known as the risk contract program, has not grown much or achieved its cost containment potential. Comparisons therefore with HMO trends in the private sector are instructive. Large employers are using market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information. Their efforts are directed at becoming more prudent and sophisticated purchasers of health care.

Today, in connection with our work on health care claims and the risk contract program, we will discuss what lessons the private sector offers for applying managed care strategies to the Medicare program.

Turning first to payment policies, one of the main reasons Medicare's risk contract program has been unable to harness the cost-saving potential of managed care has to do with problems with the mechanism it uses to set HMO payment rates. At present, Medicare does not shop or negotiate but sets HMO rates county by county using a formula tied to fee-for-service. In contrast, large employers and other purchasers can negotiate with managed care providers or shop among them for the best value.

Turning to the area of quality, the Federal Government has had quality assurance standards since the seventies, but has not enforced them aggressively in its risk contract program. For example, in the last 10 years, HCFA has repeatedly opened and closed quality assurance reviews in certain Florida HMOs because of poor quality care.

In contrast, the private sector has taken a different strategy by involving large employers as partners in setting and enforcing HMO quality standards. An independent organization, the National Committee for Quality Assurance, has developed standards and procedures for accrediting HMOs. This accreditation is becoming increasingly important since large employers are beginning to require NCQA accreditation of health plans before they can be offered to their employees.

Finally, the private sector has also taken the lead in developing information for purchasers and consumers to compare different HMOs. A group of large employers has led efforts in developing HEDIS, the health plan employer data and information set, which contains information on performance measures to evaluate plans' quality.

HCFA is beginning to define a similar set of quality measurements targeted to the Medicare population, but expects collection and publication to be several years away.

In addition, HCFA has not spurred HMOs to provide the performance data beneficiaries need to make informed choices in selecting between managed care and fee-for-service options. Even where some data exists such as HMO disenrollment rates or numbers of complaints, HCFA has not published this data which could help beneficiaries differentiate between HMOs.

In conclusion, the history of Medicare and private attempts to control health care costs is discouraging under fee-for-service. Medicare faces the overwhelming task of trying to police upward of 700 million claims each year. Private payers seeking to control costs have moved strongly toward managed care.

HCFA can now move to test proposals drawing on private sector experience. We believe it can, first, test the potential for such strategies as competitive bidding and negotiation to improve Medicare's HMO payment approach. Second, stop the enrollment of Medicare beneficiaries in HMOs that do not meet standards. And third, use its data to publish disenrollment and certain beneficiary satisfaction data in annual reports, comparing plans.

We believe HCFA should move expeditiously in all of these areas.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY OF JANET L. SHIKLES
ASSISTANT COMPTROLLER GENERAL
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to participate in your discussion on expanding managed care under the Medicare program. For the past week you have been examining weaknesses in Medicare's predominantly fee-for-service program, which cost the government $162 billion in fiscal year 1994 and consumes an ever greater share of the federal budget each year. In testimony to the Subcommittee earlier this week, we reported that the magnitude of the Medicare program has overwhelmed the government's ability to police the hundreds of millions of claims submitted annually.[1] Today the Subcommittee is examining managed care options as alternatives to the current claim-by-claim management of program dollars. What we would like to contribute is our perspective on Medicare's HMO payment policy, efforts to enforce quality assurance standards, and the dissemination of consumer information. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. II for a list of the issued reports.)

In brief, the current Medicare HMO option, known as the risk contract program, has not grown much or achieved its cost containment potential. Comparisons with HMO trends in the private sector are instructive. Large employers use market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information. Their efforts are directed at becoming more prudent and sophisticated purchasers of health care. Although the particulars of these efforts may not be directly transferrable to the federal government, their broad aims of finding incentive-based solutions to containing costs, assuring quality, and informing consumers are worthy of consideration and testing.

MANAGED CARE HAS POTENTIAL TO ADDRESS MEDICARE CLAIMS VULNERABILITY

Medicare's growing claims volume has placed substantial demands on Medicare's claims processing systems. In fiscal year 1994, Medicare processed nearly 700 million claims. In 1992 and again this month, we report that Medicare is one of several government programs highly vulnerable to waste, fraud, abuse, and mismanagement.[2] Since our first report, the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls, and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses. The nation's health care delivery system is evolving with such changes as consolidations of various provider types and increasingly complex financial arrangements. In this environment, HCFA is seeking strategies to become less reliant on reviewing claims individually as a means of guarding against overpayment.

During the last decade, employers have increasingly turned to managed care to slow the rising cost of health benefits. As the Congressional Budget Office reported earlier this month, the most effective HMOs can reduce the use of services for the nonelderly population by 22 percent over typical indemnity plans.[3] Industry estimates show HMO enrollment nearly doubled since 1986 to 50 million people in 1994. (See fig. 1.) About 90 percent of the HMO enrollees are in commercial or employer-sponsored programs.

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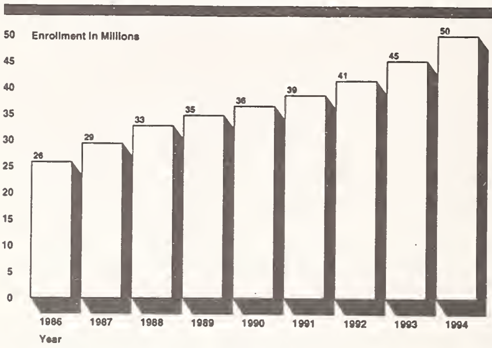
[1] Medicare: High Spending Growth Calls for Aggressive Action (GAO/HEHS-T-95-75, Feb. 6, 1995).

[2] Medicare Claims (GAO/HR-93-6, Dec. 1992) and forthcoming Medicare Claims (GAO/HR-95-7).

[3] The most effective plans were group and staff models HMOs. IPAs, another type of HMO, reduced utilization 2 to 4 percent on average. See CBO testimony on Federal Entitlement Spending, statement by Paul N. Van de Water, Congressional Budget Office, before the U.S.

Figure 1: Growth in HMO Enrollment Between 1986 and 1994



Source:Group Health Association of America (GHAA), 1994

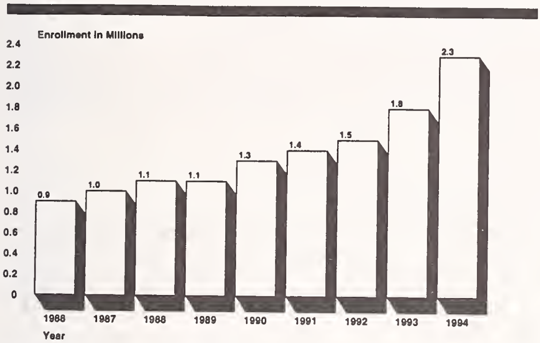
States, too, are looking to managed care to help contain the costs of their Medicaid programs. These programs now enroll nearly 8 million people in managed care plans, about half of whom are in HMOs. Several states, such as Ohio, South Carolina, and Florida, plan to move large segments of their Medicaid population into HMO-type plans in the next few years.

Like states and employers, Medicare has also tried managed care as a way to contain the cost of providing care to over 35 million beneficiaries. Medicare offers its beneficiaries the option of obtaining managed care from prepaid plans or provider networks participating in a 15-state pilot program called Medicare Select. This program offers beneficiaries the incentive of savings on their supplementary insurance premiums if they obtain care from a designated network of providers.

HMOs are the most common form of Medicare managed care. Recently, Medicare HMO enrollment growth has accelerated. In the past 2 years, the number of Medicare HMO enrollees grew 50 percent, from about 1.5 million to about 2.3 million beneficiaries. (See fig. 2.) However, since this is only about 7 percent of the Medicare population, the growth is much lower than in the general population. Medicare HMO enrollment has been uneven, with high concentration in a few areas and no enrollment in others. (See app. I.)

Senate, Committee on the Budget, Feb. 1, 1995.

Figure 2: Number of Medicare Beneficiaries Enrolled in HMOs with Medicare Risk Contracts Between 1986 and 1994



Source: Health Care Financing Administration

PAYMENT POLICIES NEEDED TO ACHIEVE MEDICARE SAVINGS

Medicare's risk contract program has been unable to harness the cost-saving potential of managed care. As we reported in 1994, Medicare's mechanism for setting HMO payment rates suffers from certain technical difficulties.[4] These may be best understood when contrasted with the private sector's rate-setting methods.

In the private sector, large employers and other purchasers can negotiate with managed care providers or shop among them for the best value. Meanwhile, with more HMOs entering various local markets, competition on price has become sharper. Some employers and other purchasers report obtaining reduced premiums compared to the prior year.

In contrast, HCFA does not shop or negotiate but sets its HMO rates, county by county, using a formula. That formula has two key flaws. First, it ties HMO payment rates to a county's fee-for-service costs. As a result, in some counties Medicare's HMO rates factor in excessive use of services and so are too high for Medicare to realize the potential savings from managed care. In other counties with lower service use, Medicare's rates are too low to encourage HMO participation in its risk contract program.[5] Second, Medicare's formula does not adequately adjust HMO rates for enrolled beneficiaries' risk of illness. This flaw in the program's "risk adjuster" results in significant losses to Medicare.

Remedies have been proposed to make Medicare managed care achieve its cost-saving goal. In particular, we have identified several promising health risk adjusters, including one shorter-term fix. Even with better risk adjusters, more fundamental changes may be required so that Medicare reduces its reliance on fee-for-service costs as a basis for HMO payment. For example, major proposed reforms include competitive bidding arrangements and negotiations between the government and HMOs.

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[4] Medicare: Changes to HMO Rate-Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[5] The rate differences can be substantial even in adjacent areas. For example, Medicare's unadjusted 1994 HMO payment rate is 28 percent lower in Montgomery County, Maryland, than in adjacent Prince George's County, Maryland.

We have also proposed administrative solutions to the inadequate risk adjustment in Medicare's payment formula.[6] For example, the required period of time that beneficiaries must stay with an HMO once enrolled could be lengthened from 30 days to 1 year. Because such restrictions "lock in" beneficiaries, additional measures would be needed to safeguard against substandard quality.

PRIVATE SECTOR LEADS IN EMPHASIZING QUALITY STANDARDS

The public and private sectors share a common interest in developing the means to ensure that HMOs provide quality as well as cost-effective care. HMOs' restrictions on individuals' choice of physicians, hospitals, and other sources of care create the need to provide payers and beneficiaries assurances that quality of care will be carefully monitored.

The federal government has had quality assurance standards for HMOs since the 1970s but has not enforced them aggressively. Medicare has a process to monitor HMOs' compliance with federal standards. It involves site visits to assess an HMO's financial solvency, quality assurance systems, and other features for ensuring the fair treatment of beneficiaries. In many instances, however, HCFA does not act on evidence of violations or make such evidence public.

For example, in the last 10 years, HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed or withheld, and test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

The private sector has taken a different approach in enforcing standards. Large employers have joined with a private accreditation agency in setting and enforcing HMO quality standards. This organization, the National Committee for Quality Assurance (NCQA), has developed standards and procedures for certifying HMOs that request accreditation.[7] NCQA certification is becoming increasingly important since large employers are beginning to require accreditation as a prerequisite to negotiating with HMOs.

PURCHASERS AND ENROLLEES NEED INFORMATION TO MAKE APPROPRIATE CHOICES

The private sector has also taken the lead in developing information that enable purchasers and consumers to compare different HMOs. To enable such assessment of health plans' cost effectiveness and performance, a group of large employers has led efforts in developing the Health Plan Employer Data and Information Set (HEDIS). These data constitute a set of performance measures to evaluate plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. Although HEDIS standards are still under development, some employers already require their plans to submit HEDIS-based information.

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[6] See Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 1991).

[7] The Group Health Association of America in conjunction with the American Managed Care and Review Association, formed NCQA in 1979. NCQA became an independent agency in 1990.

The private sector also disseminates quality-related information to purchasers and users. For example, NCQA publishes results of its medical quality assurance accreditation reviews nationwide. Of 15 Medicare HMOs reviewed in Florida, only 1 received full accreditation, 6 were denied accreditation, and 8 received less than full accreditation. With this knowledge, a consortium of employers has elected to exclude Florida's largest Medicare HMO from new business with their employer-sponsored health plans.

HCFA is beginning to define a similar set of quality measurements targeted to the senior population but expects collection and publication of these data to be several years away. HCFA has not spurred HMOs to provide the performance data beneficiaries need to make informed choices in selecting between managed care and fee-for-service options. Moreover, even where some data exist, such as HMO disenrollment rates or numbers of complaints, HCFA has not published these data which could help beneficiaries differentiate among HMOs.

The feasibility of producing and disseminating such information is apparent in a commercial document that compiles information on plans available to federal employees.[8] The publication rates the plans on customers' satisfaction with waiting times for physician office visits, access to specialty care, and making appointments. It also publishes HMO disenrollment rates.

CONCLUSIONS

The history of Medicare and private attempts to control health care costs is discouraging under fee-for-service. Medicare faces the overwhelming task of policing upward of 700 million claims each year. Private payers, seeking to control costs, have moved strongly toward managed care. Their experience suggests strategies for moving Medicare toward more of a managed care approach. As a prudent buyer, the private sector offers lessons in using market power to negotiate favorable payment rates; in being an advocate of value and quality assurance; and in educating consumers to make informed choices about health plan options.

HCFA can now move to test proposals drawing on private sector experience. It can (1) test the potential for such strategies as competitive bidding and negotiation to improve Medicare's HMO payment approach, (2) stop the enrollment of Medicare beneficiaries in HMOs that do not meet standards, and (3) use its data to publish disenrollment and certain beneficiary satisfaction data in annual reports comparing plans.

HCFA has shown a willingness to adopt these strategies by its proposals to test new reimbursement techniques, recent enforcement actions on quality, and a consumer information initiative. Because there may be policy and legislative impediments to moving aggressively in these areas, HCFA may have to ask the Congress for support.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other members of the Subcommittee may have.

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[8] Checkbook's Guide to 1995 Health Insurance Plans for Federal Employees, Walton Francis and Editors of Washington Consumers' Checkbook Magazine, Walter Francis and the Center for the Study of Services: Washington, D.C., 1994.

Table 1: Medicare HMO Enrollment by State as of January 1, 1995

State	Total Medicare Population[1]	Medicare Beneficiaries in HMOs	Enrollees as a Percentage of Total Beneficiaries	Enrollees as a Percentage of HMO Program
Alabama	619,000	1,944	0	0
Alaska	30,000	0	0	0
Arizona	561,000	**155,502**	28	7
Arkansas	410,000	0	0	0
California	3,499,000	**975,749**	28	42
Colorado	396,000	50,679	13	2
Connecticut	490,000	257	0	0
Delaware	96,000	109	0	0
Florida	2,519,000	**387,470**	15	17
Georgia	793,000	0	0	0
Hawaii	141,000	13,080	9	0
Idaho	143,000	0	0	0
Illinois	1,592,00	69,018	4	3
Indiana	802,000	2,684	0	0
Iowa	489,000	0	0	0
Kansas	379,000	0	0	0
Kentucky	565,000	2,724	0	0
Louisiana	562,000	6,636	1	0
Maine	194,000	0	0	0
Maryland	580,000	2,338	0	0
Massachusetts	911,000	41,369	5	2
Michigan	1,306,000	6,947	1	0
Minnesota	616,000	58,177	9	2.5
Mississippi	384,000	0	0	0
Missouri	815,000	14,226	2	1
Montana	125,000	0	0	0
Nebraska	245,000	3,271	1	0
Nevada	172,000	36,434	21	1.6
New Hampshire	149,000	53	0	0
New Jersey	1,142,000	5,364	0	0
New Mexico	199,000	28,147	14	1
New York	2,581,000	**104,731**	4	4.5
North Carolina	724,000	0	0	0
North Dakota	102,000	0	0	0
Ohio	1,626,000	20,816	1	1
Oklahoma	474,000	12,911	3	0.5
Oregon	454,000	**100,700**	22	4
Pennsylvania	2,041,000	60,055	3	3
Rhode Island	164,000	11,639	7	0
South Carolina	482,000	0	0	0
South Dakota	114,000	0	0	0
Tennessee	739,000	0	0	0
Texas	1,977,000	87,940	4	4
Utah	177,000	0	0	0
Vermont	79,000	0	0	0
Virginia	781,000	1,535	0	0
Washington	659,000	71,885	11	3
West Virginia	322,000	0	0	0
Wisconsin	745,000	0	0	0
Wyoming	57,000	0	0	0
Total	35,224,000	2,339,592	7	

[1] Total Medicare population as of July 1, 1993

Related GAO Products

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicare: HCFA Needs to Take Stronger Actions Against HMOS Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1, 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 7, 1989).

Medicare: Health Maintenance Organization Rate Setting Issues (GAO/HRD-89-46, Jan. 31, 1989).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Contracting (GAO/HRD-88-14, Nov. 2, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

Chairman THOMAS. Thank you very much, Ms. Shikles.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to talk a little bit about regulation. About 25 percent of the health care dollars spent right now is subject to regulation by State insurance regulation. What is your impression of State regulation, how they carry out that responsibility?

Ms. SHIKLES. The State regulation of health care?

Mr. MCDERMOTT. Yes.

Ms. SHIKLES. Actually States have a decreasing role in regulating health insurance because more and more firms are self-insuring, and they are under State health regulation.

Mr. MCDERMOTT. Who enforces quality standards if the State can't do it because of self-insurance?

Ms. SHIKLES. The quality standards are enforced by many different sectors. HCFA is responsible for quality standards in the Medicare program. Your private employers are involved with——

Mr. MCDERMOTT. They set their own standards and decide whether to follow them? Since the State doesn't do it, you don't do it, who enforces quality standards on the self-insured?

Ms. SHIKLES. There are minimum standards under the ERISA plans under the Department of Labor. If they haven't self-insured, they would be under this State regulatory market.

I think what we are seeing, and I have been doing fraud and abuse reviews for many, many years in the whole health care field, and you are really seeing a dramatic change I think in the last several years where you are finding that large corporations are getting involved not only in cost containment, but in quality reviews.

I think if you look at what is going on with Medicare and HMOs, and that was the point we were trying to make, and we have done a ton of reviews in this area, and in that case, HCFA had the regulatory responsibility, and we never saw any improvement. And I have probably done 10 reports and many testimonies, and nothing ever got better. And the real dramatic change that is going on now is that employers as purchasers are really making some major changes because they are getting so involved in the types of plans that their employees choose.

I think it is pretty impressive what is going on with the National Committee for Quality Assurance. Where there is accreditation, they publish the results. Employers now, based on the results that are published, are going to withdraw from allowing employees to participate in plans that aren't accredited.

That is faster than anything I have seen in HCFA over the past 10 years. So it is a very mixed story.

Mr. MCDERMOTT. Is the California experience, they have at least three departments, I think, that are involved in their regulation of health care. What does that do to the regulation of it? Or the oversight of it?

Ms. SHIKLES. In California I think because HMOs fall under the department of corporations and other insurance products under the department of insurance, I think they have worked to coordinate it. But I am sure it is a more confused——

Mr. MCDERMOTT. And health has the part of quality assurance, don't they? That is a third element in California.

Ms. SHIKLES. That is right.

Mr. MCDERMOTT. How do they coordinate that?

Ms. SHIKLES. I don't know. We haven't looked specifically at California's department of insurance and how they are working with——

Mr. MCDERMOTT. If you were a senior in California and you were in one of these programs and felt you weren't getting good health care, what department would you go to to complain?

Ms. SHIKLES. I think you would file your complaint with the department of insurance, I think.

Mr. MCDERMOTT. You are not sure?

Ms. SHIKLES. I am not sure. We haven't investigated California. Our focus—the work that we have done is following up on complaints in both the fee-for-service program and the HMO program in Medicare.

Mr. MCDERMOTT. You mentioned Florida. Have you done anything with Medicaid HMOs?

Ms. SHIKLES. We have not looked at Medicaid HMOs in Florida. Is that your question?

Mr. MCDERMOTT. Yes.

Ms. SHIKLES. Right.

Mr. MCDERMOTT. Would you think that an HMO that spent 63 percent of their dollar on overhead was a little bit top heavy?

Ms. SHIKLES. You would be very worried that there was very little money for the services that need to be provided, yes.

Mr. MCDERMOTT. If they spent 77 percent, would you think that was excessive?

Ms. SHIKLES. Right.

Mr. MCDERMOTT. You know, all you have to do is read—I am sorry Mr. Christensen's not here, but the Sun Sentinel did a report on HMOs in Florida, and when you look at these administrative costs of 51, 63, 55, 77 percent, you have to wonder, what are they paying for health care for these people?

I mean, I thought 30-percent profit, as some firms estimate, was a little excessive. But when you see this kind of thing you ask yourself, are they delivering any health care whatsoever?

Chairman THOMAS. Will the gentleman yield?

I just got a copy of that reprint. It is headed, "Florida's Medicaid HMOs." Are we advocating an expansion of jurisdiction here? I am with you if we are.

Mr. MCDERMOTT. We are talking about putting senior citizens into managed care by forcing them, for some mechanism, because they can now choose it.

The point, Mr. Chairman, is senior citizens can now choose to go into managed care. They don't. Only some go in.

So now if we want to save money, we are going to have to say to those seniors, OK, folks, line up, you are going into an HMO. That is the way you are going to get the savings. And if you don't do that, then you are not—I don't know what incentive you are going to give them to get them to make a choice now that they don't make.

Chairman THOMAS. The time of the gentleman has expired.

You can also argue that for the general population. However, we are looking at trends, and we have got to keep in mind this is a relatively new and rapidly changing area.

Ms. Shikles, I was interested in your statement about the private sector and the speed with which they are now informing themselves and making decisions. You heard the administrator of HCFA in response to the question from Mr. Christensen about getting a study that was in 1990, based upon the Medicare program, to be done by January 1, 1995, and they are going to get around to it sometime later this year.

The kind of timeframe in which changes need to be made simply cannot have that sort of thing happen. Do you agree with that?

Ms. SHIKLES. We do agree with it.

Chairman THOMAS. And when you say that the suggestions have to be made in a timeframe, these studies, expeditiously by HCFA, do you have any outside timeframe? Is this 5 years, 7 years?

Ms. SHIKLES. We think they should be done this year. We think that in working on the health care field, that changes that are going on in the private side of health care are so dramatic and the different types of products being offered, and the focus on quality is a really new and very strong emphasis.

And so I think HCFA could test a set of things very quickly this year that could give you much more information on how to price different products and how to do different offerings.

Chairman THOMAS. Yes, but you were here. The Administrator chose to take his time to complain about the Medicare Select program, argue that it shouldn't be made permanent, and then throw up some theoretical problems about physicians increasing their money through various schemes. Perhaps you are suggesting that it might have been a bit more valuable for this agency to provide us with some modeling of the way in which they are going to shorten the timeframe to make judgments, like the private sector has done.

Ms. SHIKLES. Right.

Chairman THOMAS. That is really valuable testimony. What I am looking for, and we will visit with you, is to find out what your agency can do to assist us in examining the tools that the private sector is using like the NCQA and take a look at potential tools that we have available to find out if we can't begin to push these government agencies' timelines into the months rather than the years.

And I hope you will be willing to work with us as we go forward.

Ms. SHIKLES. We would love to do that and we think we can offer quite a bit of assistance in that area.

Chairman THOMAS. I think once again people need to appreciate the rapidity with which change is now occurring in the private sector. It started very slowly but is now moving extremely rapidly. The longer we wait and the more we complain about the shift and the more we use anecdotes from other areas in terms of the potential downside problem for a particular group of seniors, we lose significant opportunities in terms of comprehensive care for all of our seniors, but more importantly, any savings that might be achieved from those changes are going to be pushed back. We don't have much room between now and 2001.

Thank you for your testimony.

Mrs. JOHNSON. I just wanted to comment on something you said earlier, because we did have to vote. It is interesting, the article from the Sun Sentinel reports on studies of HMOs under Medicaid. But at the bottom of that article it mentions, "This newspaper's work in revealing real fraud and bad practice in HMOs serving elderly patients." And they say, "Four years ago we did this."

In your testimony you say, in the last 10 years HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed and withheld, test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

In other words, I hear your testimony to say not that there are not some problems in some HMOs, but that the government has been totally incapable of identifying them or doing anything about them in contrast to the private sector's actions in the last couple of years where they have really focused on quality issues.

I thank you for your testimony and look forward to working with you to develop more detail in certain areas.

Mr. MCDERMOTT. Mr. Chairman, that study that Mrs. Johnson now refers to was done in October 1990. It isn't as though it happened only on the present watch. It has been going on for a long time.

Mrs. JOHNSON. Over 10 years government has showed itself completely incompetent to do it.

Mr. MCDERMOTT. Even with Republican administrations, I point out.

Chairman THOMAS. From all the testimony I heard, 1990 seems to be current day for some of these folks.

The committee stands in recess until this vote is over.

Thank you very much, Ms. Shikles.

We will ask the next panel to be ready to go. When we come back that would be former colleague Bill Gradison, Karen Ignagni and Stephen Wiggins.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

If the panel is willing, we can begin. I know the members have already reviewed your testimony, and they are going to be coming back from a vote that continues to go on.

The witnesses' written testimony will be made a part of the record, without objection.

And it is my pleasure to welcome to the committee as the first testifier, the former Hon. Bill Gradison from Ohio. I don't need to say any more than that.

STATEMENT OF HON. BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. GRADISON. Thank you, Mr. Chairman. I have turned in a longer prepared statement. I appreciate your including it in the record.

Mr. Chairman, Medicare is a highly valuable, immensely popular program which has served the medical needs of the elderly and disabled quite well over almost three decades. But the program is not perfect. And reexamining Medicare probably as you are doing is timely.

In many respects Medicare is a state-of-the-art 1965 health insurance program. Both the benefit package and delivery systems are pretty much the same as they were at the outset.

While important and useful changes have been made in the program, DRGs, RBRVSs, the HMO CMP option and Medicare Select, for example, these amount to tinkering around the edges.

In my judgment, were the Congress to design a new program today to serve the elderly and disabled, it would look very different from Medicare as we know it in at least two regards: The benefit package and the delivery system.

It is inconceivable to me, for example, that Medicare as started anew would exclude outpatient prescription drugs. I am also skeptical that a one-size-fits-all benefit package would be adopted. It is also doubtful to me that the program would be overwhelmingly fee-for-service.

Having grappled with Medicare policy for years as a member of this subcommittee, I know how hard it is to make minor, to say nothing of major, changes in Medicare.

I believe we can be helpful in your deliberations since HIAA members, whom I represent, are involved in all aspects of Medicare as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare CMP and the Medicare Select managed care options that are available to beneficiaries in many parts of the country.

Frankly we haven't focused on what specific changes to recommend were Medicare to be restructured. We do know that achieving Medicare program cost reductions through further erosion in provider reimbursements would merely shift the cost to the private sector, making health insurance more costly for the non-Medicare population and making care for the elderly population less available.

Increasing this cost shift from the public to the private sector is in essence a tax on the private sector. Quite apart from whatever major restructuring you may decide upon, Mr. Chairman, we recommend that Medicare's managed care program be expanded now. The cost reimbursement rather than risk contracts may expand access to managed care in some geographic areas.

Speeding up HCFA approval of managed care contracts would also help. This process could be streamlined particularly for managed care plans which have already been approved as risk contractors and are seeking merely to expand or enter new geographic markets.

Beneficiary satisfaction levels within current Medicare managed care plans are high. Medicare managed care choices offer lower costs, expanded benefits, less paperwork, coordination of care, and case management.

Obviously for today's elderly population, a network-based delivery system is largely foreign to them. They should not be forced to participate but rather be given incentives. Many private sector plans offer managed care to their current employees.

HIAA would suggest the development of a mechanism to permit a retired employee to remain in the employer's managed care plan and have that become a Medicare option. For those retirees who choose to remain in the employer's plan, the ability to assure seamless continuation of their coverage would greatly enhance beneficiary satisfaction.

The Medicare Select program is one example of a managed care initiative that is working now to give seniors the option of saving money by moving into a PPO setting. HIAA strongly supports the expansion of this program to seniors in all 50 States and making the program permanent.

In closing, Mr. Chairman, we stand ready to work with the Congress on Medicare restructuring options and health care reform in general. Of course, we will need to see the details of various proposals before we will be able to comment on the specifics. It is healthy that discussion is taking place about a new paradigm for managed care plans.

Well-managed network-based care is a partnership of providers, payers and beneficiaries. All of these parties should participate in discussions regarding the restructuring of this important government program.

Thank you for this opportunity to be present today.

[The prepared statement follows:]

TESTIMONY OF HON. BILL GRADISON
HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Bill Gradison, President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the nation's commercial health insurers, covering 55 million Americans. I am delighted to have the opportunity to participate in this important hearing on the future of managed care in the Medicare program.

HIAA member companies are involved in all aspects of Medicare: as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO, CMP and Medicare- Select managed care options that are available to beneficiaries in many parts of the country.

Among the HIAA member companies involved in Medicare managed care are Bankers Life and Casualty, FHP, Healthsource, Humana, Intergroup, New York Life, Principal Health Care, Sierra Health and Life and Wellpoint. Outside of Medicare, our member companies have enrolled over 25 million of the 100 million Americans estimated to be in managed care plans. Their record in Medicare is similar. They have enrolled nearly 700,000 of the 3 million seniors covered by plans under contract with Medicare.

Looking into the future, Medicare managed care plans will enjoy large gains in enrollment as the current working population covered by managed care will choose to continue to have managed care when they retire. But, unless the overall structure of Medicare is radically altered, there will always be a substantial Medicare fee-for-service population that will want to purchase traditional Medicare supplemental insurance to augment their Medicare benefits.

Over the past decade, Medicare's managed care options have become an increasingly important part of the program - and deservedly so. They offer seniors the benefit of coordinated health care, as well as coverages, such as prescription drug coverage, not provided by Medicare, at a very competitive cost. Yet, the growth of the Medicare managed care has been considerably slower than the rapid expansion of managed care enrollment in the under age 65 population.

Currently, Medicare managed care contractors cover just over 3 million beneficiaries. Compared to the rapid expansion of managed care in the private sector, particularly, among employee group health benefit plans, Medicare managed care, despite recent favorable enrollment trends, has not kept pace. We believe that there are several reasons for this. They have to do with basic differences between Medicare and the employee health benefits market, incentives for managed care plans, the lack of an adequate spectrum of Medicare managed care options for beneficiaries or adequate efforts to inform them about the existing ones, current Medicare beneficiaries' lack of familiarity with network-based delivery systems and, finally, a tendency by government to sometimes overregulate rather than rely on the marketplace to produce desired results.

Risk Contracting

The Health Care Financing Administration (HCFA) is seeking to expand the role of Medicare managed care to help contain its burgeoning program costs. For a variety of reasons, HCFA has come to prefer contracting with managed care plans on a risk rather than cost reimbursement basis. Yet, after ten years of risk contracting with HMOs and Competitive Medical Plans (CMPs), there is still a lively debate over whether the premium that Medicare pays to risk plans is adequate compensation for the risk to be assumed, or is too generous.

Medicare pays risk HMOs and CMPs a premium calculated at 95% of the average annual per capita cost (AAPCC) for Medicare beneficiaries in a plan's operating area. HCFA seems to believe that HMOs and CMPs tend to enroll younger, healthier Medicare beneficiaries. It is argued that this positive selection makes a premium based on 95% of the cost for an average (older and sicker) beneficiary too high, despite the fact that the managed care plans provide a richer array of benefits than is covered by the fee-for-service segment of Medicare.

On the other hand, those who believe that risk premiums under the current formula are inadequate argue that many new enrollees in Medicare managed care plans join because they have been unable to afford Medicare's cost sharing requirements or supplemental insurance. They enroll in a Medicare risk HMO or CMP because the cost sharing requirements are minimal, and, once enrolled, their previously unmet health care needs far exceed the care utilized by an average Medicare beneficiary. Low income beneficiaries, they say, are four times more likely than average beneficiaries to enroll in a Medicare HMO or CMP. This phenomenon may be a major reason why, over the past decade, a substantial number of risk plans have dropped out of the program or have converted to cost-reimbursement contracts.

Many health policy experts believe that if managed care can capture a substantial portion of the health care market in a given area, its ability to provide more benefits for a lower premium will exert a competitive cost containment effect on the entire health care market place. Medicare risk contractors complain, however, that where they have achieved a sizable share of the Medicare beneficiary market - thus driving down the average cost per Medicare beneficiary - the 95% AAPCC formula "rewards" them by diminishing the premium paid by the government to 95% of the lower average.

It may also be appropriate for the government to temporarily ease some of the regulatory requirements for managed care contractors, in the interest of opening new managed care markets. We believe that this can be done, carefully and selectively, without sacrificing the critical elements of consumer protection and quality assurance. However, all plans, in all markets, should have to be certified under the federal HMO law, or state-licensed - in order to assure appropriate oversight of their solvency, fiduciary responsibilities and the quality of care they provide their customers.

Other Obstacles

Our member companies report that it takes up to a year and a half to meet all of HCFA's information requirements and receive approval of a managed care contract proposal. They believe that this process could be streamlined and reduced to less than a year.

HCFA could be authorized to waive some aspects of the application process that are redundant for those managed care plans who have already been approved as risk contractors and are seeking to expand or enter into new geographic markets.

Congress and the Administration might also consider reducing the redundancies that exist with respect to the oversight of quality of care. Managed care plans are reviewed by state regulators and may also be reviewed by private accrediting organizations. It would be useful if appropriate private managed care accreditation could be accepted by Medicare.

Anti-managed care laws, such as any-willing-provider statutes, whether state or federal, can only undercut Medicare's interest in promoting managed care among its beneficiaries. Requiring a network to contract with all providers in its area increases the cost of delivering care and network sponsors are concerned that it may negatively impact quality. Federally qualified HMOs are exempt from the statutory obstacles that have been erected in a few states. Competitive Medical Plans (CMPs), Medicare-Select, and yet-to-be developed additional managed care options for Medicare beneficiaries, should have the same status as federally qualified HMOs.

The Medicare/Medicaid anti-kickback laws frustrate the offering to Medicare beneficiaries of many innovative managed care arrangements that are common in the private sector. Only fee-for-service discounts enjoy a safe harbor under the existing law.
While the federal concern about kickbacks is a legitimate one, there needs to be greater accommodation of worthwhile managed care practices that are effective and serve the interests of consumers.

Beneficiary Satisfaction

Medicare beneficiaries can drop out of managed care plans almost at will. This makes beneficiary satisfaction a critical ingredient that must be addressed by any strategy for expanding the Medicare managed care population.

While beneficiaries drop out of Medicare HMOs and CMPs at much higher rates than they do in private sector managed care plans, the GAO advises that two thirds of those who leave a Medicare HMO or CMP do so to join another one with more attractive benefits.

A more substantial problem than disenrollment is the reluctance of many of today's beneficiaries to enroll at all in managed care options. Managed care networks are foreign territory to them. Even the availability of extra benefits such as coverage for prescription drugs and elimination of the need to pay premiums for Medicare supplemental insurance are insufficient incentives for most of them give up long-term relationships with their physicians.

Except for emergency or out-of-area care, Medicare HMO and CMPs require beneficiaries to get their care within the contractors' delivery systems. In order to broaden the appeal of managed care, Medicare needs to create additional options, emulating private managed care plans that provide consumers managed care coverage while allowing them to sometimes use out-of-network providers if they are willing to accept a reduced level of benefits, such as higher copayments, when they do so.

In 1990, Congress took a major step toward broadening the spectrum of Medicare's managed care options by authorizing a 15 state demonstration of a preferred provider organization (PPO) type of Medicare supplemental coverage called Medicare-Select. This option does allow beneficiaries to use out-of-network providers at the cost of receiving reduced coverage for their services. While the demonstration got off to a slow start, it is now growing rapidly and promises to be attractive to beneficiaries. As discussed below, we urge Congress to move quickly to make Medicare-Select a permanent, national Medicare option.

Another option that would dramatically increase Medicare beneficiary satisfaction with managed care could be based on managed care employee health benefit plans. Many of these plans offer their enrollees greater freedom-of-choice than the current Medicare HMO and CMP options. What needs to be developed is an option that would permit a retired employee to remain in the employer's managed care plan, with Medicare becoming a partner in financing the benefits. The retiree could still choose to enroll in the fee-for-service segment of Medicare, or choose another available Medicare managed care option. For those retirees who chose to remain in the employer's plan, the ability to assure "seamless" continuation of their coverage would greatly enhance beneficiary satisfaction. There have been a couple of successful demonstrations of this concept. What is needed now is a focused effort aimed at making it available nationwide.

Medicare-Select

The Medicare-Select program is one managed care initiative that is working now to give seniors the option of saving money on their Medicare supplemental insurance policies by joining a preferred provider network.

Medicare-Select expands choice for consumers by making Medicare supplemental insurance coverage more affordable, without sacrificing important consumer protections. The program was designed to bring seniors' choices up to date with PPO products widely available to the under 65 population.

In those 15 Medicare-Select states, over 400,000 seniors are paying 10% to 37% less in premium dollars for the exact same
benefits offered by traditional fee-for-service Medicare Supplemental policies. This translates into savings of as much as $25 per month or $300 per year for individuals living on fixed incomes, making over $120 million dollars worth of purchasing power available for other uses by those seniors who are now participating in the program.

For the consumer, Medicare-Select offers more flexibility than the Medicare HMO program. Under the Medicare HMO option, if a individual selects a doctor or hospital outside the network,no Medicare benefits are paid. Under the Medicare-Select program, if services or care is provided outside the network, the beneficiary is still entitled to receive the full normal Medicare reimbursement, and a reduced supplemental benefit is paid. If care is provided by the network's hospitals or physicians, the full Medicare-Select benefit is paid.

The Medicare-Select program is one example of a flexible benefit package that offers seniors another way to protect themselves from health care costs. In addition to monthly premium savings, there are out-of-pocket savings for seniors as well. By seeking care from Medicare-Select networks, subscribers are protected from balance billing.

And, like all Medicare supplemental insurance policies, Medicare-Select products are among the most tightly regulated products today. Current rules safeguard consumers by requiring networks to offer sufficient access, ongoing quality assurance programs, and full disclosure of network requirements. In addition, Medicare-Select plans that offer a fee-for-service product must allow consumers to convert to that product at any time.

Consumer satisfaction is probably the best recommendation for expanding Medicare-Select to all 50 states and making this demonstration program permanent. The August 1994 edition of Consumer Reports, rated the top Medicare supplemental insurance products nationwide, and of the top 15 rated products, 8 were Medicare-Select. In fact, the Research Triangle Institute's interim study of February 10, 1994, indicates that there were no consumer complaints in any of the Medicare-Select states.

HIAA encourages the Congress to act quickly to extend Medicare-Select. Without Congressional authorization, the Medicare-Select program will be expire on June 30, 1995. Unless Congress acts by April 1, over 400,000 beneficiaries will be notified that their supplemental insurance network will no longer be able to take on new members. This will only create confusion and uncertainty. Seniors in Medicare-Select states will not have the choice of using a preferred provider option for their Medicare supplemental insurance benefits. That would be an unsatisfactory answer for the public and for seniors who have challenged us to make government not only smaller, and more efficient, but also more responsive to their needs.

Medicare-Select is one important example of a managed care element that is working now to help protect seniors from the high cost of medical-expenses, without shifting costs to the federal government, and without sacrificing quality medical services.

In closing, the HIAA stands ready to work with the Congress on restructuring Medicare managed care options and on health reform in general. As the details of various proposals become known, we will be glad to provide you with more informed comment upon them. Thank you for the opportunity to participate today.

Chairman THOMAS. Thank you very much, Bill.
Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. Thank you Mr. Chairman, Mrs. Johnson.

I am president of the Group Health Association of America. Our 375 members serve 80 percent of the 50 million Americans receiving health care from HMOs today. We thank you for allowing us to testify and would like to review three issues with the committee.

First is the success of the current Medicare HMO program. Second, a long-term vision for bringing the Medicare program up to date for beneficiaries. Third, mechanisms to move toward the vision beginning with the short-term changes.

I might say in commencing, as changes are made in Medicare, we do support reaffirmation of the fundamental goal of the program: To afford older Americans the security of access to a core set of benefits. The Medicare HMO contracting program is success by the most important measure we can identify, the satisfaction of beneficiaries who have chosen this approach.

During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied with their health plan regardless of health status than fee-for-service subscribers.

There are many reasons for beneficiaries to be satisfied with their Medicare HMO. The track record of the plans is impressive.

Second, there is tremendous coordination of care. Quite a lot of discussion was had on that point earlier, and I don't want to repeat much of it, but to rephrase an essential point, which is that within an HMO there is coordination of care among teams of physicians and other health care practitioners utilizing the spectrum of available services.

Third, there is less paperwork filled out and fewer, more predictable, out-of-pocket cost, which is a significant issue that I think has not yet been fully discussed this morning.

Despite these advantages, Medicare lags significantly behind the private sector in making available options. The question meriting attention by the committee is why. The answer may point the committee to short-term and long-term solutions.

First, the long term. It is crucial that this committee begin its work by developing consensus on its vision for the future. From there an implementation plan can be developed to achieve these goals. With all due respect, we think it is very difficult to work the other way around. We believe that it is crucial that Medicare beneficiaries have the same choices as those under 65.

Second, beneficiaries should have a choice of health plans that meet comparable standards for quality access and solvency. The range of choices should include fee-for-service as well as HMO and other managed care options.

Third, we have been examining efforts to contribute to the body of evidence in discussions with respect to payment methodology and we are now in the process of examining a variety of market-based pricing structures and we hope to have more specific recommendations on those and other reimbursement issues in the future. In the very near term future, I might add.

Next, the Medicare payments to health plans we believe should be risk adjusted using more sophisticated methods. There was a comment earlier about moving in the current system to metropolitan statistical areas. We think some of the thinking that is going on there needs to be focused in terms of market-based pricing structures.

In our view, every market beneficiary should receive comparative information on the choices available to them. An open enrollment period should be available in each geographic area. However, we want to join those who have raised issues concerning a single 1-month or less open enrollment period for all beneficiaries. We think those would be very difficult to administer and not necessarily in the best interests of beneficiaries. We also join with those who have raised concerns about lock-ins.

Mr. Chairman, we are mindful of the budgetary imperatives facing the economy and the need for all of us to ask if it will increase the rate of spending. The overwhelming evidence we believe suggests that it will. And I would be delighted to answer questions about some of the studies that have been discussed earlier today.

Now is the time to begin, in our view, moving forward in order to bring the Medicare program up to date. And there has been quite a lot of discussion on that.

We do think that there are some short-term issues, Mrs. Johnson, to your question, that might be looked at as a way of moving from where we are to this longer term vision. First, in our view, that involves encouraging choices for Medicare beneficiaries. Many, many individuals report to us they are simply not aware of the many options that currently exist, and I think we probably need to do a better job in that regard.

We join with those who support moving forward on the Medicare Select program, and believe we should move to the longer term vision after that.

Second, developing the statutory criteria to guide the Secretary in providing waivers of the 50-50 enrollment requirement is something that should be examined. Directly calculate fee-for-service costs in computing the AAPCC rather than estimating costs and then netting out estimated HMO payments that you are estimating twice.

There are a number of other issues that have been talked about in our testimony. Again, I would be delighted to comment on that.

I think as members of this committee and others throughout the Congress look at the Medicare issues, the thing that we can contribute, we believe, most importantly is our experience. We would be delighted to work with you, your staff, by providing the track record of what is out there, by commenting on the existing studies that have been done, and bringing to bear the experience of the 375 plans that we represent that have a track record, have a vision, and want to work together with you to refashion the program in the interests of beneficiaries.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KAREN IGNAGNI
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Introduction

Mr. Chairman and members of the Committee, I am Karen Ignagni, President of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 375 member HMOs serve 80 percent of the 50 million Americans receiving health care from HMOs today.

GHAA and its member plans come to the committee not as theorists or academics, but as the nation's largest body of practical, market-based expertise in making HMO options available to beneficiaries and in operating successful plans. We are pleased that the committee is looking at the success of Medicare risk contracting and opportunities for expanding HMO and other managed care choices available to Medicare beneficiaries. We thank you for allowing us to testify this morning, and would like to review four issues with the Committee:

- The success of the current program in which Medicare beneficiaries are offered an HMO/CMP[1] choice;
- Medicare's problems as it lags behind the rest of the health care market in its use of HMO and other managed care arrangements;
- A long-term vision for bringing the Medicare program up-to-date for beneficiaries; and
- Mechanisms to begin to move toward that vision, requiring phased transitions, and starting with some short-term changes in the existing program.

As changes are made in the Medicare program, we support reaffirmation of the fundamental goal of the program -- to afford older Americans the security of access to a core set of health benefits. The program should be strengthened to guarantee the continued fulfillment of the nation's commitment to its older citizens.

Success in offering beneficiary choice under the Medicare risk contracting program

As of this January, 3.1 million Medicare beneficiaries had chosen to be served through one of the HMO contracting options offered by the Medicare program. Since 1990, the enrollment in Medicare risk plans has doubled while combined enrollment in all HMO options has grown by 70 percent. Further , there are 209 plans participating in the Medicare program, representing an increase of 48 percent over the number of plans participating 5 years ago (risk contracting plans alone have increased by 60 percent).

The Medicare HMO contracting program is a success by the most important measure we can identify -- the satisfaction of the beneficiaries who have chosen this approach.
During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied overall with their health plan than fee-for-service subscribers. This is true for the elderly as well as Americans under the age of 65. Figure 1 is

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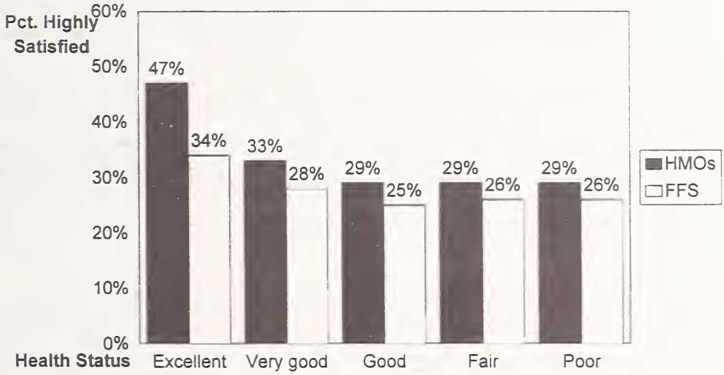
[1] Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

based on a national survey of over 19,000 elderly Americans conducted by the National Research Corporation based in Lincoln, Nebraska. The graphic shows that for all levels of self-designated health status, the elderly enrolled in HMOs are more satisfied with their coverage than the elderly receiving services under the traditional Medicare fee-for-service program. This graphic emphasizes that HMOs achieve higher subscriber satisfaction not just among the healthy, but also among the sick. This is one reason that HMO enrollment continues to grow -- among the young and healthy, and among the older and less healthy populations.

There are many reasons for beneficiaries to be satisfied with their Medicare HMO. First, beneficiaries fill out much less paperwork. Under the fee-for-service Medicare program, beneficiaries file claims paperwork every time they receive services. In Medicare risk HMOs, the paperwork required of beneficiaries is little more than the application to join the plan.

Figure 1

Medicare HMO Members Are More Satisfied with Their Coverage than Medicare Fee-for-Service Beneficiaries, for All Levels of Health Status.



National Research Corporation Survey of 19,523 Elderly Households, 1994

Another benefit to seniors is coordination of care and a comprehensive care orientation. HMOs make preventive services not covered by the fee-for-service Medicare program broadly available to the beneficiaries who select them. The beneficiary's primary physician not only keeps track of all medications and tests that the beneficiary receives within an HMO, but the physician helps the beneficiary coordinate health care from specialists and hospitals. HMOs treat beneficiaries on a continuing basis, as whole persons rather than series of ailments.

In Medicare HMOs, beneficiaries have fewer and more predictable out-of-pocket costs and fewer worries about coordination of out-of -pocket and government payments. Medicare coinsurance and deductibles are translated into a monthly premium so that rather than paying 20 percent of the cost of services after the deductible is met, a beneficiary in an HMO usually pays a nominal copayment (usually $5 or $10) for doctors' services.

Finally, in addition to these benefits, Medicare HMOs offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service sector.[2] This is due to coverage and improved access to preventive care under comprehensive HMO coverage which was also highlighted in a study by the Center for Disease Control and Prevention (CDC) and the National Center for Health Statistics.[3] The CDC study showed that women in HMOs are more likely to obtain mammograms, pap smears and clinical breast exams than those in the fee-for-service sector. Another study which supported the HMO approach to care compared the process and outcome of care for hospitalized HMO and fee-for-service patients age 65 and older with acute myocardial infarction (heart attack). This study, published in the American Journal of Public Health, concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.[4] These are just a few of numerous studies showing that Medicare HMOs provide care of an equal or higher quality than that provided by the fee-for-service sector.[5]

Medicare lags behind the rest of the Market

While HMOs and other managed care plans have proven successful in private markets, and in meeting the needs of 3.1 million Medicare beneficiaries, Medicare lags significantly behind the private sector in making available managed care options. Twenty-two percent of individuals with health insurance in the employer-based market were enrolled in HMOs in 1993, and an additional 29 percent are enrolled in a preferred provider organization or point-of-service plan.[6] Under Medicare, approximately 9 percent of beneficiaries are enrolled in HMOs.

While some degree of caution is always appropriate in implementing changes in a program like Medicare, the gap between Medicare and the private market is now far too wide. Medicare was originally designed to provide the elderly, and later the disabled, with health coverage and access to services comparable to that of the rest of the population. But the private health care market has changed dramatically -- most notably in the increased use of HMOs and other types of managed care. Medicare has not similarly changed.

The question meriting attention by the Committee is why? I would suggest two sets of answers -- one short-term, one long-term.

The short-term answer is that the current Medicare risk contracting system, despite its success in some markets, has several problems.

First, the payment methodology, known as the adjusted average per capita cost (AAPCC), is flawed. Payment rates are tied to the Medicare fee-for-service costs in a given area, and do not give the Medicare program the benefits of market dynamics present in the private sector. Problems with the payment methodology have also inhibited expansion of risk contracts in some geographic areas. In addition, the payment rates are unstable from year to year, which makes planning difficult for HMOs. Further, risk adjustment factors must be improved.

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[2] G. Riley, A. Potosky, et al., "Stage of Cancer at Diagnosis for Medicare HMO and Fee-For-Service Enrollees," 84 *Am. J. Public Health* 1598 (October 1994).

[3] *CDC/NCHS Advance Data No. 254*, August 3, 1994.

[4] D. Carlisle, A. Sui et al., "HMO vs Fee-For-Service Care of Older Persons with Acute Myocardial Infarction," 82 *Am. J. Public Health* 1626 (December 1992).

[5] *See* D. Clement, S. Retchin, R. Brown, and M. Stegall, "Access and Outcomes of Elderly Patients Enrolled in Managed Care," 271 *J. Am. Med. Assoc.* 1487 (May 18, 1994); S. Retchin, D. Clement, et al., "How the Elderly Fare in HMOs: Outcomes from the Medicare Competition Demonstrations," 27 *Health Services Res.* 651 (December 1992); J. Preston and S. Retchin, "The Management of Geriatric Hypertension In HMOs," 39 *J. Am. Geriatrics Soc.* 683 (July 1991); N. Lurie, J. Christianson, et al., "The Effects of Capitation on Health and Functional Status of the Medicaid Elderly," 120 *Annals Internal Med.* 506 (March 15, 1994).

[6] KPMG Peat Marwick/Wayne State University Survey of 1,953 Firms, 1993.

Second, some HMOs that are well established in the Medicare program are unable to expand their enrollment despite interest from Medicare beneficiaries because no waiver authority exists from the requirement that no more than 50 percent of a plan's membership can be comprised of Medicare and Medicaid beneficiaries.

In addition, not all Medicare enrollees know about their HMO option. Upon becoming eligible for Medicare, enrollees learn only about fee-for-service Medicare and do not receive information about available HMO options.

Longer term vision

The longer-term answer is that Medicare's overall program design must begin to keep pace with the evolution -- and revolution -- taking place in health care. Let me lay out for you GHAA's longer-term vision for bringing the Medicare program up to date.

Medicare must keep its vitally important promise of health care benefits for the elderly and disabled -- objectives that reflect the key interests of beneficiaries, the government and taxpayers, and health plans.

Beneficiaries should be able to choose the form of Medicare coverage that best meets their needs, including both fee-for-service and HMO and other managed care options. Beneficiaries should have incentives to choose high quality plans that provide Medicare services in a cost-effective manner; and current and future beneficiaries should have the security of a Medicare program that is financially viable and sustainable for the long-term.

Government interests include predictable and fiscally responsible spending; assurances that the payment structure provides health plans and beneficiaries with appropriate incentives for high quality, cost-effective health care; and a program that encourages continuing improvement and innovation in health care and keeps Medicare up-to-date with the evolving health care system.

Health plan interests include a program with realistic incentives and opportunities to meet the needs of the Medicare population; predictable policy; and incentives to organize and deliver high quality care in a manner that minimizes Medicare and beneficiary costs -- health plans should have the opportunity to attract and retain enrollment by keeping quality and service levels high and premiums competitive.

We believe that we must aim toward a system like that prevailing for some of the nation's other large purchasers of health care -- notably, the large employer purchasers. Individuals should have a choice of a wide range of qualified health plans under Medicare. Medicare, as sponsor, should set its premium contribution for Medicare benefits, set reasonable standards and monitor qualified health plans, and then let individuals choose among competing health plans -- including fee-for-service (FFS) coverage. We have identified four initial policy areas that must be addressed, and would like to present our preliminary thoughts in these areas -- standards for health plans; payments to health plans; benefits; and enrollment and marketing mechanisms.

Health plans: Beneficiaries should have a choice of health plans that meet comparable standards for quality, access, and solvency. The range of choices should include fee-for-service, as well as HMO and other managed care options.

Payments: Medicare payments to health plans should eventually be "market-based". Under such a system, qualified competing health plans should establish their premiums for Medicare benefits; and the government should set a contribution level in each market based on some percentile of a weighted average of those premiums. If the premium of the health plan selected by a beneficiary is greater than the government contribution, the beneficiary would pay the remainder. As with the current risk contracting program, Medicare payments to health plans should be risk adjusted. Therefore, it will be important to implement risk adjusters that are more sophisticated than those presently in use.

Benefits: All health plans seeking to participate would have to provide at least the Medicare benefit package defined in statute. Rules must be established for offering benefits beyond the Medicare package, either as part of a plan's basic offering or in the form of supplemental benefits.

Enrollment/Marketing: The enrollment and marketing mechanisms must ensure that beneficiaries can make informed choices. In every market beneficiaries should receive information on all the choices available to them in a form that allows them to make comparisons between different types of plans and among different benefit offerings.

Open enrollment periods must be available in each geographic area during which beneficiaries can enroll without underwriting restrictions. However, a single, massive, one month open enrollment period for all beneficiaries would create logistical, administrative and service delivery nightmares. Given the huge size of the Medicare program, significant enrollment changes in such a 30 day period would pose serious problems for HMOs and other organized plans that must be prepared to deliver care to all those who enroll and therefore, would place service to beneficiaries at risk. In order to increase the availability of HMOs and other managed care options, open enrollment rules must be established in a way that allows them to optimally accommodate enrollment changes.

Mr. Chairman, we are mindful of the budgetary imperatives facing the committee -- and the need for all of us to ask whether such changes will reduce the rate of increase in Medicare spending. We believe they will.

The strategy for controlling future Medicare outlays is not to seek just a one-time savings but to reduce the annual rate of increase. For the past three years, HMO premiums have increased more slowly than per capita costs for the Medicare program. For example, a GHAA survey reports that HMO premiums will decline 1.3 percent in 1995, whereas the Congressional Budget Office projects Medicare to increase about 10 percent a year until the end of the century.

Moreover, recent studies find that rather than shifting costs, the increased presence of HMOs leads to lower rates of increase in the fee-for-service sector. A soon to be published Georgetown University study reports that hospital costs for large hospitals located in high penetration HMO metropolitan areas increased 71 percent between 1984 and 1991 compared to 98 percent increases in metropolitan areas with low HMO penetrations.[7] A 1994 Urban Institute study concludes that for each 10 percent increase in the Medicare risk population's share of the Medicare market, per capita expenses in the Medicare fee-for service sector decline by 1.2 percent.[8] (Figure 2).

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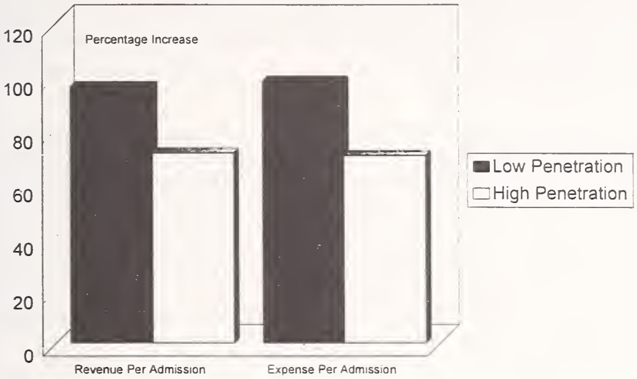
[7] J. Hadley and D. Gaskin, "HMO Penetration and Academic Health Centers: Hospital's Mission," 1984-1991, Forthcoming in *The Proceedings of the Assoc. Of Academic Health Centers*, 1995.

[8] W.P. Welch, "HMO Market Share and its Effect on Local Medicare Costs," in H.S. Luft, *HMOs and the Elderly*, Health Administration Press, Ann Arbor, Michigan, 1994, pp 231-250.

Figure 2
Hospital Expenses Rise More Slowly in Metropolitan Areas With High HMO Market Penetrations, 1984-1991.



Source: J. Hadley, Georgetown University

HMOs, moreover, achieve these savings under a system that subsidizes inefficiency. Beneficiaries and employees can choose more expensive plans and pay no more out of pocket for premiums. With a reorganized system of incentives whereby all stakeholders --- patients, providers, and health plans -- receive financial rewards for making efficient decisions, then the marketplace can produce unparalleled long-term savings.

The market-based system and payment methodology described above will be a critical element in achieving a lower the rate of increase in Medicare spending as health plans compete to serve this population. Such a structure of competing managed care and other plans will provide the framework and incentives for all of us to make such a system work for the Medicare program -- as it already does for many privately insured individuals.

One key question underlying all of this is the matter of risk selection. As I said earlier, we strongly support the development and implementation of risk adjusters appropriate to the Medicare population. But we take issue with a recent study that has biased the debate on this subject.

The HMO community believes that the Mathematica study came to an erroneous conclusion that the Medicare risk contracting program increases Medicare expenditures. First, the study did not make some of the adjustments necessary to ensure that fee-for-service costs are accurately compared to costs for beneficiaries in HMOs. It made no adjustments to the AAPCC for the working aged or individuals who receive their care from the Veterans Administration System. Since Medicare expenditures for the working aged and users of the VA system are substantially lower than expenditures for other beneficiaries and these individuals remain largely in the fee-for-service sector, the AAPCC estimates used in the study for annual reimbursements of fee-for-service enrollees are too low.

Second, Mathematica made no allowances for the spillover effect of HMO competition. W.P. Welch of the Urban Institute has estimated that for metropolitan areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Even Mathematica's econometric work found a spillover effect; however, the authors discounted this as implausible. We believe that as HMOs increase their market share and markets become more developed, the competitive effect of the fee-for-service sector will grow further.

Finally, as the HMO population has grown in the past few years, we believe that the characteristics of the HMO population become increasingly similar to those of the fee-for-service population. We observe recent surveys of the Medicare population that compare HMO and fee-for-service enrollees and find that the populations appear very similar. This was not the case a few years ago. We are involved in a number of studies testing the Mathematica conclusions.

Transition to the new system

Medicare is a vitally important program for 36 million aged and disabled Americans. In moving toward our vision for the future of this program, we ask that the Congress proceed in a planned, staged manner, and monitor and make changes as we go along. The "big bang" theory of implementation simply will not work, and will do a great disservice to the program.

However we must move forward in order to bring the Medicare program up to date so that it continues to fulfill its promise. As the program stands today, it will fall farther and farther behind the evolving health care system, placing it at increasing political and financial risk. We will be pleased to work with the Committee and staff on both the long-term approaches and mechanisms to transition to such policies over a period of years.

Short-term changes

In addition to developing the long-term vision and transition mechanisms, it is important in the short-term to make changes in the current program that will help expand choices for Medicare beneficiaries.

One such mechanism is the Medicare SELECT program -- a demonstration program under which Medigap plans can use selected, preferred provider networks to meet the needs of enrollees. This 15 state demonstration program was extended at the end of the last Congress, but just until the end of June, 1995 -- less than five months away. It currently serves about 400,000 beneficiaries, and we urge the Committee to take rapid action on Representative Johnson's bill (H.R. 483) to expand this option permanently to beneficiaries in all fifty states.

Second, we believe it important to make changes now in the existing Medicare contracting program. We strongly oppose short-term budgetary price setting "fixes" such as a floor or ceiling on payment rates -- payments to HMOs will fall automatically as part of any budgetary reductions in provider payments or increases in cost sharing. GHAA has developed the following consensus recommendations regarding short-term changes in the contracting program.

- Develop statutory criteria to guide the Secretary in providing waivers of the 50/50 enrollment requirement for health plans after they have established a history of success in the Medicare program.

- Change the rating areas for setting Medicare's adjusted average per capita cost (AAPCC) to MSAs, to make rates more stable and more reflective of service area-wide costs.

- Directly calculate Medicare fee-for-service costs in computing the AAPCC, rather than estimating total costs and netting out estimated HMO payments.

- Begin to structure demonstration projects to lay a foundation for the market-based restructuring of Medicare, such as by demonstrating market-based premium setting and government payment methodologies.

- Work on strategies for implementation of risk adjusters.

Mr. Chairman, as Congress and policymakers continue to consider restructuring the

Medicare program to expand HMO and other managed care participation and choices, we strongly urge that the first priority be serving beneficiary interests and needs. Efforts to make the program more cost effective must be carried out within this framework. HMOs can be a critical element in developing an effective strategy to provide quality care to beneficiaries while at the same time decreasing the rate of Medicare cost escalation. However, they cannot bear the entire burden of solving the Medicare cost problem. Short-term, unrealistic efforts to generate savings through HMOs will be particularly damaging to the longer term effort, because they will harm the infrastructure needed to increase capacity to serve larger numbers of beneficiaries. Similarly damaging will be imposition of anti-managed care requirements, such as any willing provider provisions.

We are continuing to work out details of our long-term vision, as well as transition proposals, and look forward to contributing to the effort to redesign the Medicare program. We believe that an expanded role for HMOs and other managed care organizations holds great promise for beneficiaries, the government and health plans. We would be pleased to work with you, and all of the members and staff of the Committee, as you consider the future of the Medicare program. Thank you.

Chairman THOMAS. Thank you very much.

Mr. Wiggins.

STATEMENT OF STEPHEN F. WIGGINS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, OXFORD HEALTH PLANS, INC., ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL

Mr. WIGGINS. Thank you, Mr. Chairman.

I am here today on behalf of the Healthcare Leadership Council, which is a group of companies in the health care industry. We represent virtually all parts of the health care industry. It is mostly represented by the leadership of those companies, from the pharmaceutical, the provider side, physicians, HMOs.

I would like to today go off the reservation a little bit here from my prepared remarks and instead address a few things that came up earlier. For starters, I would like to introduce myself. My company, which I started 10 years ago, is the fastest growing public HMO in the country. We are also one of the two fastest growing Medicare risk contractors. We enroll 3,000 to 4,000 Medicare enrollees each month out of a total of about 15,000 to 20,000 enrolling each month in our plans. We have 580,000 people that we cover. We are in Connecticut. We are in New York. We are in New Jersey. We are moving into Pennsylvania.

I would like to say one thing as emphatically as possible. That is, that seniors love these programs. It is clear to me that once they are in, they stay in. Ninety-seven percent, 96.4 percent, of our enrollees stay in the program. Over 98 percent would recommend the program to a friend. And I think that is clear evidence that people want to be in these programs.

Chairman THOMAS. Do you have any statistics? If you have them there, how many were in programs similar to that during their working life?

Mr. WIGGINS. Very few, because metro New York is unusual in that there wasn't much managed care penetration.

Chairman THOMAS. So you are laboring in a field that was not very fertile prior to your coming into it.

Mr. WIGGINS. We are the first-time plowers of those fields. It is no surprise they are joining because the benefits are tremendous.

In our program, there is no premium. We eliminate the deductible. You get full comprehensive benefits. There is preventive care, which you don't have in Medicare. There is no coinsurance, generally speaking. We also cover things like eyeglass reimbursement. There is some prescription drug coverage. So if you are a senior, it is a panacea. And the biggest problem our marketing people have is convincing enrollees that this is for real.

I think I would like to also dispel the myth that we can selectively choose who joins. Anybody can join. We have meetings at diners. Anybody that comes to the diner can get in. The seniors are a pretty communicative group. They talk among each other. They are a very discerning population. They ask one another what health plan they should join. And you generally don't just talk to your healthy friends. You talk to your sick friends too. And we get a fair range of customers.

Once those customers are in my health plan, I expect to have them for life. I presume that they will be in my health plan until they die. With a 96.4-percent retention rate, I would otherwise have Medicare enrollees for 20-some years, however, their life expectancy is often under 5.

Moving to potential improvements in the Medicare program, obviously, who could argue with promoting choice. I think a big improvement in the system would be to look at Medicare and regulate it more like the SEC style regulations of public companies; have file and use statutes. Right now they try to micromanage virtually everything.

A second thing I would say is this idea of a certificate brought up by Mr. Roper. I believe once health plan managers understand this idea, it would be welcomed by the HMO community.

Additionally, I would like—I wish Mr. McDermott were here because his mother, if she lived in New York, could join my health plan without any questions asked. There are laws in New York that require me to take any individual regardless of their health status or age. If you live in New York right now, you can join Oxford irrespective of your health status or any other factor, whether you are old or young, sick or healthy.

A couple of other issues I would like to touch on: First, risk adjusters and this idea of adverse selection. A few years ago in the commercial market everyone thought what was happening in the commercial market was that the HMOs were taking all the young, healthy people. Well, interestingly, nobody anymore talks about the young, healthy people going into the HMOs, because now that in the commercial market so many people are in HMOs, the law of large numbers has taken over.

We have an average spread of risks. In fact, a program like mine with 17,900 physicians, all board certified or recently board eligible with virtually every teaching hospital in New York, I believe I get more than my fair share of tough risks.

I also think all the adjustment tools to adjust risk are very crude. I am aware of the three tools that are available in the market. They would all create sinister incentives which I would be happy to go into. Karen already talked about the absolute folly of a 1-month open enrollment.

I can't imagine hiring a staff for 1 month and then furloughing them until next year. I can't imagine that Americans would tolerate 1 month only of free choice. I believe that you have to provide that on a rolling basis, and HMOs I believe would be more than willing to accept anyone, any time.

Finally, I don't understand why you are not talking about a defined contribution program instead of a defined benefit program here. If you are a business you would say, OK, we can only spend so much, we have got this 2001 time bomb ticking, and I would advocate we shift away from this idea of a defined benefit to a defined contribution. If you say, we are going to give health plans 90 percent of Medicare fee-for-service costs, I will stay in the process, and if you freeze it for 5 years, I would still stay in the program, because there is such excess capacity in the provider community that for a long time I can achieve the ends you seek.

My time is up. Thank you very much.

[The prepared statement follows:]

STATEMENT OF STEPHEN F. WIGGINS
HEALTHCARE LEADERSHIP COUNCIL

Mr. Chairman and Members of the Subcommittee. I am pleased to be here today on behalf of the Healthcare Leadership Council to discuss with you much-needed improvements in the Medicare program. The Healthcare Leadership Council was formed in 1988 by representatives of each of the various sectors of the health care industry, including doctors, nurses, hospitals, managed care companies, and pharmaceutical and medical technology manufacturers. HLC members are the leaders in the health care industry, working to discover, develop and deliver high quality, innovative and cost-effective health care products and services.

The Healthcare Leadership Council is committed to enhancing consumer choice through the promotion of a market-based health care delivery system. Although Medicare program improvements are not a panacea for balancing the budget, one thing is clear -- long-term cost containment in the Medicare program is dependent upon modeling the program on private sector success. Introducing market-based options into the Medicare program will provide greater choices for Medicare beneficiaries and reduce overall program expenditures through competition. Simply put, the same private-sector choices that are available to the under-65 population should be made available to the over-65 population.

My company, Oxford Health Plans, serves over 580,000 people in New York, New Jersey and Connecticut. Our Medicare program is one of the fastest growing in the nation, adding 3,000 to 5,000 seniors per month. A few facts about our programs deserve mention, because I believe they reflect the advantages of market-based solutions.

- First, Seniors like these programs and choose to stay in them. Our retention rate of Medicare members exceeds 91%. Over 95% would recommend this program to a friend, and in fact many do. Anyone unhappy with our services is free to choose another health plan. This choice is the ultimate expression of our free market system; the power of the individual to take their business elsewhere. Improvements to the Medicare program should promote this continuous free choice of health plans. Clearly, Seniors today are casting their personal votes of confidence by joining managed care programs in record numbers.

- And it's no wonder why. Seniors joining plans such as Oxford's Medicare program enjoy much better coverage. There is no need for supplemental insurance, as benefits include preventive exams, prescription drugs, expanded skilled nursing care and home care, and eyeglass reimbursement. There are no deductibles to pay and no claim forms to submit. All for no monthly premium. One of the biggest challenges our marketing people face is to convince prospective enrollees that this program is for real.

- Seniors are careful consumers. They look to their peers for advice, and the wisdom of years makes them leery of marketing representatives. They've seen it all and have the luxury of time to carefully evaluate and compare the various options available to them. We have found that the best way to communicate with this discerning population is to allow them to meet with, and to question, our existing Medicare members.

- Oxford's Ambassador Program seeks volunteers from among our enrolled seniors who are willing to attend meetings and talk privately with prospective members. These unpaid Ambassadors describe their own experiences and are free to speak their mind. Can you think of a more compelling quality assurance mechanism?

- We are able to deliver expanded benefits at a cost less than the government now spends because our medical cost management programs successfully eliminate wasteful practices and promote healthier lifestyles.

Under the current Medicare risk contracting program , my incentives are simple. I want to cover the total health care needs of enrolled Seniors for no more than the reimbursement available from the federal government. Because of the high level of customer satisfaction and correspondingly high retention rate, I expect to cover each Medicare member for the rest of their life. This gives Oxford an enormous incentive to promote healthier lifestyles and to identify health problems early, before they become serious.

While Oxford has experienced significant success in serving the Medicare population, a number of barriers exist under the current program that both limit the number of private plan options made available to beneficiaries, and that make it difficult for beneficiaries to opt-out of the fee-for-service program and into a private option plan such as ours. A number of improvements could be made that would achieve greater participation in private health plans.

- The number and type of plan options available to Medicare beneficiaries is limited to HMOs and competitive medical plans. Beneficiaries do not have access, for example, to point-of-service (POS) plans. To maximize competitive efficiencies, beneficiaries should have the right to choose among the full array of private options for health care coverage that are available to you and to me in the private marketplace, and we must assure a that a level playing field exists.

- To facilitate enrollment in private health plans options, HCFA should coordinate and sponsor a series of designated annual open enrollment periods for Medicare beneficiaries. In addition, HCFA should facilitate the marketing of private coverage options by distributing information to Medicare beneficiaries regarding all available plans in their area, much like the current process under the Federal Employee Health Benefit Program (FEHBP). Currently, HCFA does little to inform Medicare beneficiaries of their options under the risk-contracting program.

- HCFA should establish standards for disclosure of clear, precise and truthful information of plan benefits to Medicare beneficiaries, including coverage restrictions and beneficiary cost-sharing requirements, to assure quality for beneficiaries, and to avoid confusion and potential misrepresentation of covered benefits. Pre-approval of marketing materials is costly and time-consuming. Rather, HCFA should implement an SEC-like "file-and-use" system to better facilitate marketing of private plan options to beneficiaries.

- Ultimately, the Medicare program should be completely privatized through a system that gives seniors the right and the opportunity to exercise their own purchasing power.

Programs like Oxford's can continue to work as long as the federal government is a responsible partner. Through fair and predictable premium payments, a streamlined administrative process, and efforts to facilitate voluntary beneficiary enrollment in private plan options, government will attract more health plans and thereby achieve substantial cost savings.

Mr. Chairman, the private market is working, as evidenced by the rapidly declining rate of growth in health care costs and increased access to countless new and innovative health care products. Total private sector health costs increased only 2.5% in 1994, with many health plans actually reducing premiums for enrollees. The market has been and will continue to be responsive to the demands of health care consumers for lower cost, higher quality care.

We at HLC are prepared to work with you to advance the market-based health care system and ensure consumers quality, affordable health care. Thank you and I would be happy to answer any questions.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

It is a pleasure to have all of you here, each one of whom I worked closely with in various circumstances.

In your testimony, Mr. Wiggins, you talk about the barriers to your ability to offer this kind of option. It is extraordinary, and I wish the other members of the committee were here to hear about the access that seniors could be having to more care with no Medigap premium costs. It is astounding that so much of the world doesn't know about this. And I thought if you would mention a little bit more about the barriers as you see them to expansion of choice, and leave time for Ms. Ignagni and Bill to come in on a couple of things as well.

Mr. WIGGINS. Well, expansion of choice or expansion of enrollment?

Mrs. JOHNSON. Expansion of enrollment. Let's do that first.

Mr. WIGGINS. First of all, as I believe was reflected in earlier testimony, we do not enjoy an administration of this program that is very favorable to HMO enrollment.

We have 4 percent of the people who enroll in our Medicare program, then disenroll before they become effective just because of the letter that arrives from HCFA that scares the daylights out of any senior coming into the program.

Another thing——

Mrs. JOHNSON. Could you provide us with a copy of that letter?

Mr. WIGGINS. Sure.

In fact, I may have a copy with me.

[The following was subsequently received:]

EXHIBIT O

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
IMPORTANT MEDICARE INFORMATION

ADVANTAGE 65 has notified Medicare that you have joined their health plan. The effective date of your membership is 03/01/93.

ADVANTAGE 65 is a health plan that has a contract with the Federal Government to provide medical care to Medicare beneficiaries. Under the contract with the Federal Government, Medicare makes a monthly payment to the health plan for each Medicare beneficiary who joins. In return, ADVANTAGE 65 must provide or arrange to provide all of the medical care you need that is covered under Medicare. They also must provide any other benefits agreed to under the contract with Medicare and with you. ADVANTAGE 65 is approved to serve members who live in a specific geographic service area.

We are sending you this notice to remind you of the special rules that apply to you as a member of ADVANTAGE 65. As soon as your membership in the health plan is in effect,

- you must receive all of your medical care through ADVANTAGE 65 doctors and hospitals. If you use other doctors or hospitals, YOU WILL HAVE TO PAY for the care you receive.

THERE ARE ONLY TWO EXCEPTIONS TO THIS RULE. THE EXCEPTIONS ARE:

1) *EMERGENCY SERVICES:*

Emergencies are those situations when you need medical care immediately because of a sudden illness or injury and the time needed to reach ADVANTAGE 65's doctors or hospitals would mean risk of permanent damage to your health. In an emergency it does not matter if you are inside or outside your plan's service area, you should go to the nearest hosptial or other health care provider to get care. ADVANTAGE 65 will pay for emergency care you need whether or not you go to a provider affiliated with their plan.

2) *OUT OF AREA URGENTLY NEEDED SERVICES:*

ADVANTAGE 65 will pay for your care if you have an unexpected acute illness or injury while you are outside the plan's service area. This coverage is only available to you if:

- you are temporarily outside the plan's service area;
- your illness or injury requires medical attention to prevent a serious deterioration to your health; and
- required medical attention cannot be delayed until you return to the service area.

You may seek the care you need from a nearby doctor or hospital. If you do receive emergency or urgently needed care from a doctor or hospital not associated with you health plan, you should tell your plan as soon as possible. This is so they can oversee and arrange any follow-up care you may need.

EXHIBIT O

If you have an urgent medical problem while you are inside the service area, but it is not an emergency, you must get care through your health plan. You should contact ADVANTAGE 65 for instructions on what to do.

Please be sure to read the materials ADVANTAGE 65 sends you as a member of their plan. These materials explain the rules of the plan and tell about the benefits they provide. They also explain your Medicare appeal rights. If you disagree with a decision ADVANTAGE 65 makes about a service you believe they should cover, you have a right to appeal. Your membership materials give details on your appeal rights. If you need more information about your right to appeal and how to request it, call your Social Security office or your health plan.

We recommend that you let family members and friends know about your membership in ADVANTAGE 65, especially anyone who may help arrange your medical care.

If you wish to end your membership in ADVANTAGE 65, you may do so in person or by writing directly to your health plan or your local Social Security office. Your membership will end on the first day of the month following the month that ADVANTAGE 65 or Social Security receives your written request for disenrollment (unless a later date is requested).

Your health plan can answer any questions about this notice, or your enrollment in ADVANTAGE 65. When you write to your health plan or to Medicare, include your membership number that appears on your plan's ID card and your Medicare Health Insurance claim number that appears on your Medicare card.

This Message is from:

Health Care Financing Administration--Medicare
1-G-2 Oak Meadows Building
6340 Security Boulevard
Baltimore, MD 21207

—SAVE THIS NOTICE AND KEEP IT WITH YOUR IMPORTANT PAPERS—

U.S. Department of
Health and Human Services
Health Care Financing Administration

Mr. WIGGINS. Another thing that I think is a big problem is we don't know who the Medicare enrollees are so we walk into Brooklyn or——

Chairman THOMAS. We want to make sure those numbers are correct. What was your retention rate in the program?

Mr. WIGGINS. Eight percent of the total people that we sign up do not stay in our program after the first year. Four percent never get to their beginning date of coverage because they have got this letter from HCFA and they disenroll after they have signed up.

That is not uncommon, by the way, in the HMO risk contracting program. And they have modified the letter, to their credit, over time. And it may not just be the letter. It may be other factors as well. They may reconsider, and there is probably some legitimate disenrollment there.

But in specific answer to your question, Nancy, I would like to suggest that one of the ways that you could promote enrollment is work with the HMOs a little more. We have simply asked HCFA to send a letter out. It would sure be nice if they just tell people about our availability. Instead, we have to get databases, employ large telemarketing units, using a kind of a Braille method to find senior citizens, which increases our marketing cost. If the Federal Government could just promote a little more of this option, I believe you would have massive enrollment.

Regarding the way we enroll, we have ambassadors who go to diners and sit with people who are thinking of getting in the program. Sometimes they say things we don't want them to say, but this ambassador program of unpaid volunteers who show up to talk to their fellow seniors, that is the way seniors like to come into a program like this. They are very discerning and often skeptical potential customers.

Mrs. JOHNSON. When you talk about the government helping reduce marketing costs, do you have any idea what the average profitability is of the kinds of plans that serve seniors?

We have heard some extraordinary figures given earlier, and I know you don't work to that kind of profit margin, but I wondered about the rest of the industry.

Mr. WIGGINS. My aftertax profit on premiums is generally just under 4 percent. That is I believe what you need to attract private enterprise. And for the amount of money that we collect, we generally deliver a benefit that is far superior to what they are getting in traditional Medicare. Everybody is happy. No one is a loser, including the Federal Government, who is saving money.

I disagree with the Mathematica study. I think it is fundamentally flawed. It is scary to think about a debate on this subject using the Mathematica study as a foundation for this debate.

It is old. It doesn't reflect the realities of getting increased enrollment into health plans. Karen can probably go point by point through the fundamental flaws of that study. But I would be afraid of using that right now to talk about Medicare reform.

Mrs. JOHNSON. Karen, in your testimony you say that recent studies find that rather than shifting cost, the increased presence of HMOs leads to lower rates of increase in the fee-for-service sector. And you conclude that a 1994 Urban Institute study concludes that for each 10-percent increase in the Medicare risk population's share of the Medicare market, per capita expenses in the Medicare fee-for-service sector declined by 1.2 percent.

Now, given that information, do you have any idea why HCFA persists in believing that the Medicare risk market and the Medicare Select market provide no savings to the Federal Government?

Ms. IGNAGNI. I think we have had a precedent throughout various sectors with respect to cost estimation that the practice has been to rely on published data, so that you would not, in making judgments, have access necessarily or reach out to find some of the newer data that are available. Indeed, as Mr. Wiggins said, that is the fundamental flaw of the Mathematica study.

Since that study was done, I know, Mrs. Johnson, you are aware that enrollment in Medicare HMOs has increased 50 percent, as have the numbers of individuals participating, that is to say, plans.

So there is that issue. The CBO estimation with respect to HMO effectiveness we believe suffers with the same lag problem with respect to data. Now that you are poised to make major changes, it seems prudent to stop and take a look at the track record we now know exists. Dr. Welch's study, Dr. Hadley's studies, show very important spillover effects. That should be taken into consideration.

Mr. GRADISON. With respect to the question of coverage, we have been talking with quite a few of our members recently about Medicare Select in anticipation of the hearing today. And we came away with the impression that there are a number of insurers and HMOs, of course, which would come into this program if it is made permanent.

A 3-year program is not a powerful incentive to set up all the systems that are involved. So our best judgment is that if it is made permanent, you are going to see a lot of new competitors in the 15 States where it is already permitted.

Mrs. JOHNSON. Thank you. That is an excellent point.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

With all the opportunity that is out there, this continues to baffle me, that HCFA is not willing to move into a little more accelerated examination of options. I think it is fairly clear where their heart is in terms of not even willing to move forward and making permanent what we think is a very simple practice. I guess it is a heart transplant they need more than anything else.

Plus, and this is where I need some help, there was no question that earlier on there were very few insurance products available for seniors, that was one of the reasons there was a major move for Medicare.

To what extent, though, has the creation and the ongoing presence of Medicare been an inhibitor in obviously developing products for that segment of the market given the way in which it is fundamentally structured? And to what extent do we have to be bold again in going to a new model rather than timid, where you never, ever do get a full understanding of the products that could be available?

And the other side of the coin of that is the whole risk selection argument, that you are going to wind up with the healthier seniors going into these programs and Medicare becomes the insurer of last resort, which if that is the case I would like to know what the numbers are and what the profiles are, because we can deal with that if that is the result.

Mr. GRADISON. In a sense the creation of Medicare created an opportunity in the private sector, that is to say, Medigap insurance was built as a wraparound policy to a government program, but it was fundamentally built upon the fee-for-service model, which was the way Medicare was created, and that was the world at that time.

I think that one of the difficult conceptual issues in thinking about this is that managed care itself has changed a great deal over recent years from what it used to be. While there are certainly all varieties—there is a broad spectrum of different kinds of managed care plans out there, the most dramatic growth appears to be in plans such as PPOs and point-of-service plans and plans that in other ways offer out-of-network options. That seems to be where the market is growing most rapidly.

And in that sense, the discussion of managed care for Medicare beneficiaries as an option which will limit choice is sort of yesterday's argument, not the future of the program.

Now, I appreciate that that is not the way in which it is perceived by most of the beneficiaries. But I would suppose if you are thinking of restructuring, to pick up on the excellent point made by Karen Ignagni, you would want to figure out where you want to be at a certain point in the future, as your goal, and then figure out the steps necessary to get there.

I am somewhat baffled that there is as much controversy about Medicare Select. I don't think the Sun will fail to come up tomorrow, whether you expand it or don't expand it. It is a very useful program but it really isn't at the heart of restructuring Medicare.

Chairman THOMAS. If we are going to have as much trouble in terms of not getting an agreement on something like Medicare Select and the timeframe in which we have to rethink what we are doing, it just gets a little frightening about the educational curve that we are on with some folks.

Mr. GRADISON. Exactly, Mr. Chairman.

Ms. IGNAGNI. Mr. Chairman, I was just going to observe, trying to cut through a lot of the complexity and admittedly there is quite a lot, if an individual is ill and knows that, I can't imagine the rationale for remaining in the existing fee-for-service system where we know about the copays, the deductibles, the barriers with respect to price. We know about the barriers with respect to administrative responsibility in terms of forms and paperwork.

But we also know that from the studies that we have done, the reason that individuals are exceedingly happy about HMO coverage is that under coordinated care, there is a comprehensive care orientation throughout the system, a very complex one, and I think as we get into exploring the reasons for individuals moving into HMOs, I think you will find some of the newer data suggesting that those who are chronically ill, indeed very ill, are most drawn to a coordinated system of care, which takes you from the point of preventive services to tertiary services and everything in between.

That, to me, is worth something for beneficiaries, quite a lot. I am not so sure we have adequately evaluated that.

Chairman THOMAS. To go back to a point that was made or attempted to be made with the GAO witness, obviously the private sector is moving very quickly, and it is difficult sometimes for government to respond with measuring tools that are meaningful in the new environment.

Clearly HCFA has difficulty in providing those tools. We have seen some examples mentioned of the private sector attempting to create tools for itself to measure quality and cost relationships.

What have you folks who have been out there in the real world experienced with States and their ability to develop measuring tools that are meaningful? Or is the private sector again a 3- to 5-year lead on this? Are there tools out there that you are becoming aware of that would be useful to us in attempting to profile some models for measuring quality and cost?

Ms. IGNAGNI. As you know, there is a plethora of regulation out there. Speaking for our plans, our plans are complying with regulations and statutes associated with the Federal HMO act. They are also complying with and are regulated at the State level for HMO products.

Third, the employers are now using external accreditation mechanisms such as the NCQA, mentioned by Dr. Vladeck, and for the private sector as well as for other kinds of products. So there are a number of other mechanisms out there.

The concern, however, is the need to move to a system where there is a level playingfield across products, hoping and offering the same kinds of services in the market today, or in the future. And it seems that as we talk about appropriate regulatory mechanisms for HMOs, we need to—and our industry has fully supported that and has been in dialog both with employers as well as Federal and State regulators, we also need to think about the same kinds of regulations extending across other products so that at the end of the day the beneficiaries will have the comfort that in fact there are these kinds of comparable regulatory mechanisms.

There has been quite a lot going on in the HMO world. There is very little if anything going on in the fee-for-service side.

So we do have a system of a black box there that I think we need to get our hands around as we move forward to talk about expanding choice. There are some issues that need to be attended to with respect to quality, quality monitoring and assurance in the fee-for-service sector as well as all other sectors.

Mr. GRADISON. Mr. Chairman, for markets to work well, they need information. And the information available to permit intelligent choices in the health care today is inadequate. It isn't that it is not accurate. It is just you can't compare it very well.

I think we need some mechanism which probably could be done by government or the private sector—probably more quickly by the private sector—to figure out what data is important, and then maybe some separate mechanism to monitor the system to see that the data that is coming up from the individual plans is comparable, one to the other, and that they are doing it in a fair and appropriate way.

I don't want to take a shot at HCFA because I recognize the problems that they have. Keep in mind they have been trying for years to put out comparative data on hospital mortality under Medicare and they have had difficulty with coming up with something that is accepted as being fair and meaningful, particularly with regard to the severity issue. And they stopped under Dr. Vladeck, and I can see why. And that is a relatively simple thing compared with some of the other comparative data that some folks, including ourselves, would like to have.

I have one other just very brief but general point that I would like to make which is actually in defense of HCFA, Mr. Chairman, and that is that I haven't seen a situation in or out of health care in which government regulation could keep up with changes in the marketplace. I would say that based upon my 18 years of experience, that I had where you are. I would talk about banking, savings and loans, railroads, trucking, before you ever get to health care.

So I think the fundamental assumption that governments, State or Federal, either one, can move as fast as the innovations in the marketplace are taking place, is just unrealistic. It isn't a question that people aren't trying hard. I just don't think it is possible for them to do it, no matter how hard they work, no matter how able they are.

Chairman THOMAS. Yes, but I do believe there are some things that we can do, especially at the Federal level, and one of the things that shocked me most about getting more involved in this area was the lack of information. When you got it, it was 3 to 5 years old, and the world had changed; you were simply looking at a historical model that wouldn't help you at all.

In terms of the outcomes, tests, computerization, administrative simplification, those are the kinds of enabling things I think we could do at the Federal level. Get some uniformity in malpractice so that as you begin collecting this data, it is more reliable. You can do it in a quicker period of time so that you can begin to yardstick the thing.

What concerns me, though, and I will go back to the HCFA question, is that rather than focusing on that and understanding that we might be able to, in the short run, adopt some tools that the private sector is utilizing. I believe that the front end is the difficult part, as more and more people transition from work into this program, and have a comfort level with managed care because of their previous condition. What we ought to be doing is creating a threshold for those folks who have no yardstick or over the years we should develop a comfort level.

What bothers me most about what I am hearing from HCFA in terms of the roadblocks they are trying to put up is a little bit like the Japanese car test program. That is, we want safe cars here so just crash every one that is imported and we will be able to determine whether or not they are safe.

There doesn't seem to be a willingness to focus on the need for change in a timeframe to make that change. And we are willing to do everything we can at this end to provide a structure. But if we are going to attempt to reinvent HCFA on a private sector model in the timeframe that we need to do it, we can't do it, in my opinion.

So I am looking for yardsticks, measurements, formulas that you folks have found to be successful that will attempt to incorporate into a model to provide for the opportunity to allow people to walk over into that private sector by choice.

And I don't understand why, and I would like to see the letter that HCFA has been putting out or even the modified letter that HCFA has put out, why we aren't creating at least an umbrella of understanding that this is an option and a reasonable one available.

The gentleman from Nebraska.

Mr. CHRISTENSEN. I am going to pass.

Chairman THOMAS. The gentleman from Washington.

Mr. MCDERMOTT. Mr. Wiggins, I was looking at some data that is provided to us, companies providing managed care, this Oxford bunch. Last year you spent 69 cents of every dollar on patients.

Mr. WIGGINS. That is incorrect. That is the percentage of our total revenues that went to health services, included in revenues is what is called the administrative services only premium. You have to gross up what is our self-funded business to a fully insured equivalent to derive a loss ratio, which is meaningfully higher. The number you use is not a loss ratio and probably comes out of a proxy or something.

Mr. MCDERMOTT. Are you an economist or what are you? If it says 69 percent——

Mr. WIGGINS. Yes, I am the economist for Oxford Health Plans.

Mr. MCDERMOTT [continuing]. What are you doing with the rest of it?

Mr. WIGGINS. Our medical loss ratio varies by line of business. We generally develop products that deliver comprehensive health benefits for the commercial market. It might be anywhere from 10 to 25 percent below the cost of a fee-for-service plan. And for that much reduced premium relative to the commercial market, we are able to deliver, as I said, a much more comprehensive program.

Of my commercial employer customers, 98.6 percent stayed with the program in the last 2 years. That is our annual retention rate of commercial customers. So nobody seems to be complaining about the composition of the cost structure in our program.

And, in fact, now that we are going into another year of zero premium increase year over year, which was our 1994–95 adjustment, I anticipate that they will continue to not have a great difficulty with the composition. I would like to address your Medicaid point earlier, because we are also one of the fastest growing providers of services to the Medicaid population in New York and probably the only company making major investments in developing provider sites to serve the poor in inner-city neighborhoods. For instance, we are developing clinics in East New York, which is the highest crime area of Brooklyn.

And what you find in Medicaid is that it is not at all like a commercial employment group. We have to hire outreach socialworkers that go into the homes to do what I have called a VP. We do a visual preview, because most of who we cover, the ADC population, which is the mothers——

Mr. MCDERMOTT. Why do you have to go in and look at their house? You deliver health care; what the heck does the house have to do with it?

Mr. WIGGINS. We are trying to lower the infant mortality rate and we have successfully done that in the Medicaid program. It takes a significant amount of money——

Mr. MCDERMOTT. What factors in infant mortality do you get from looking at the house?

Mr. WIGGINS. You try to assess as best you can how "at-risk" a pregnancy might be.

Mr. MCDERMOTT. So it is at-risk. What do you do?

Mr. WIGGINS. You put caseworkers on it and try very hard to make sure you bring that pregnancy to full term.

Mr. MCDERMOTT. What does that caseworker do?

Mr. WIGGINS. You are in the face of the mother. You are there often. You are trying to teach them about proper nutrition. When possible, you are trying to make sure they get to the providers most appropriate for their needs. Making sure they are getting in for their examinations in a timely manner to assure that they don't have a high-risk situation.

Many of the mothers on Medicaid happen to be high risk. And it is important to identify those situations early.

Mr. MCDERMOTT. Can you terminate them?

Mr. WIGGINS. No.

Mr. MCDERMOTT. So once you got them, you are stuck with them, no matter what they do?

Mr. WIGGINS. That is right.

Mr. MCDERMOTT. And——

Mr. WIGGINS. By the way, in New York, as I mentioned, you weren't here, we take everybody without question. We take individuals enrolling in the plan, Medicare, Medicaid, anybody that wants into Oxford Health Plans can join any day of the week.

Mr. MCDERMOTT. Under Medicare, if HCFA would risk adjust, would you still take people?

Mr. WIGGINS. Sure, we would. I think risk adjusters are a mistake. I am aware of the three computer tools that are available right now to risk adjust. You could use ambulatory groups, you could use the Peer-a-Med system or the Symmetry system. Those would be the three most valid ways to risk adjust. Those are tools we use right now. I am familiar with their advantages and disadvantages.

You will find that in risk adjusting populations, that demographics explain most of the variance. There is very little variance that is explained beyond demographics by these severity adjusting tools. And so it is a little bit folly, because it is like the fly on the elephant. It is just not going to help you much to know what the risk ad——

Mr. MCDERMOTT. Explain that in C–SPAN language for people who don't know all the medical terms. What do you mean by risk adjustment?

Mr. WIGGINS. Risk adjustment is a way to determine how sick somebody is and then vary the payment to an HMO based on your assessment of how healthy or sick they are. Of course, as you know, people can change quickly. And so you might have somebody that has an assessment coming in that is very different 2 months in.

In addition, much like the Federal DRG program which has led to terrible fraud and abuse out in the marketplace, where doctors, as I know you are a physician, are trained now in our Nation's hospitals how to get the coding right to get the reimbursement higher at the hospital. Risk adjusters will lend themselves to the same type of gaming, and for that reason—I think that is one of the reasons I think they would be a very bad tool to use.

Mr. McDERMOTT. Your basic view is that you should not use a risk adjustment, you should give a flat fee for everybody, and that is it, not even for age?

Mr. WIGGINS. Age is valid. Once you get above 30 or more percent of the population in HMOs, you have already spread the risk meaningfully enough that you no longer need to worry about risk adjusters. There is an even spread in the HMOs and there is an even spread outside the HMOs.

Mr. McDERMOTT. You are basically for community rating?

Mr. WIGGINS. I am very much in favor of community rating. And I think you could solve the problems that you addressed earlier here by having a community rating structure that forces me to take any Medicare comer. It is conceivable you could even include end-stage renal disease.

Mr. McDERMOTT. Did you hear that, Mr. Gradison?

Mr. WIGGINS. I am talking for myself now.

Mr. McDERMOTT. I understand that. That is why——

Mr. WIGGINS. I have lost the Health Care Leadership Council reservation.

Mr. McDERMOTT. I had a feeling you were wandering off the text.

Would you agree to that, take all comers?

Mr. GRADISON. That is exactly the way Medigap works today. At 65, when you become eligible, it is guaranteed issue. It is only people who wait until later who don't want to keep up their premiums, that the ratings and the preexisting condition limitations are happening. So that with regard to——

Mr. McDERMOTT. You mean if they bought it at 65—and never drop a payment?

Mr. GRADISON. I am saying there is guaranteed issue at 65. Today, that is the standard approach to Medigap insurance. That is the way it works.

Chairman THOMAS. Ostensibly the gentleman's time has expired, but he is scoring so many points for us I want him to just keep going.

Mr. McDERMOTT. I want it on the record so that we can ultimately discuss it, because not everybody believes what Mr. Wiggins said.

Chairman THOMAS. The gentleman understands the framework.

Mr. McDERMOTT. If you want me to go on, I would love to.

Chairman THOMAS. Your line of questioning is more beneficial to our coming to a conclusion than ours, because when you agree, you don't really try——

Mr. McDERMOTT. That is because you have got the votes.

Chairman THOMAS. I will tell the gentleman, I have been sitting here since 10 a.m. not because I have the votes. I have been sitting here because I want to listen to people who I think have answers. That is why I am sitting here.

The gentleman from Nebraska will question.

Mr. CHRISTENSEN. I just wanted to make a couple comments. First I wanted to thank the panel. I am sorry that I didn't get a chance to hear your entire testimony but I am going to read it because I am very intrigued as to the options and ideas that you have.

I also want to say my hat is off to the young man in this crowd who can't be more than 12 or 13 years old, who has been enduring this for a long time. You are to be——

Ms. IGNAGNI. It is Mr. Wiggins' son.

Mr. CHRISTENSEN. You are a fine young man.

Mr. WIGGINS. He has Sonny Bono's signature here.

Mr. CHRISTENSEN. I want to ask the panel if they have any ideas on why the administration "punted" on their responsibility as far as the budget goes this year with reform in terms of Medicare. Have you heard anything as far as the administration's viewpoints toward addressing this area, anything in general?

Ms. Ignagni.

Ms. IGNAGNI. I was hoping you wouldn't turn to me first, frankly. What comes to mind is one has enough trouble explaining one's own actions, it is very difficult to explain somebody else's, but I suspect that what needs to be said is that some of the discussion is quite new with respect to a full look at the Medicare program.

I think several months ago no one would have predicted that we would have been here talking about a fundamental change in direction potentially for Medicare, while assuring the promise that was made back in 1965, and I would suspect that many individuals from across the political perspective and spectrum, as I know within our organizations and probably many others are beginning to just now get their hands around what that means and the potential for moving forward in a variety of directions.

I think the Chairman's notion and challenge for the witnesses which we have tried to take very seriously is to think broad, think bold, and try to be as helpful as we can in pointing a direction.

What also needs to be said is I am not sure everyone has thought fully about the steps that would be necessary seriatim to move from A to B, and we want to be very helpful in that, but I want to be quite frank in saying that we are going to have quite a lot of additional discussion within our own ranks.

Mr. CHRISTENSEN. Congressman Gradison, is there any doubt in your mind at all—you have been here on the Hill for several years of your life, been involved in public service, and now you are on the other side in terms of the private sector—is there any doubt in your mind who can help solve this problem? Is it the government or can it be better solved and better managed through private sector options, private sector ideas like Mr. Wiggins talked about a little bit ago? Not that I agree with everything that he said because I am opposed to community rating, but I liked what he said in terms of addressing Medicare.

Mr. GRADISON. First off, the last major changes of any consequence in national health care legislation occurred almost 30 years ago. That tells you how hard it is to bring about changes. That was Medicare and Medicaid, 1965. That I think is interesting.

I think that what is happening, and this has been true with administrations of both parties, and Congress, as it turns out, of both parties now as well, is that the promises made in 1965 are turning out to be difficult to fulfill. They are just very expensive, more expensive, far more expensive than was anticipated, and that creates a real problem of what do you do about it, pony up more money or somehow cut back on the programs or some combination of the two.

The third thing that has happened is that there has been a tremendous change in the way health care is delivered and financed in this country over recent years, and the pace seems to be accelerating.

Now, to come directly to your question, what runs through my mind, this isn't a direct but it is intended to be a very significant, I mean meaningful response to you, what comes to my mind was the experience we had with Medicare catastrophic. It blew up on us. I was one of a handful that went down with the ship and voted against repeal, but what it turned out was that—there are a lot of ways to interpret what happened, but one way to interpret it is that most Medicare beneficiaries like the program the way it is, and therefore it is hard to change it. That I think is a simple-minded but accurate way to say it.

We thought we were at the time—I am not trying to beat a dead horse—but we thought we were improving it for the vast majority of the beneficiaries, but that didn't seem to be the message that came through in the end, so I guess that there is just a warning flag out there.

For those of you who didn't live through that experience, it was traumatic. I carry it around with me, I actually have it in my desk—a photograph of the signing ceremony. Here is Ronald Reagan, he signed it, and here are a number of people, some of whom would be here today if the full committee or subcommittee were here, including this guy, beaming with pride.

Within 1 year later it was repealed, the first and I think only social program in the history of this country that was repealed before it took full effect. So it is just a sensitive program. It is hard to work with it, hard to change it.

Mr. CHRISTENSEN. I have got a quick question before my time runs out. On the Oxford Health Plan, did you start that company?

Mr. WIGGINS. Yes.

Mr. CHRISTENSEN. How many employees do you have now?

Mr. WIGGINS. I have got about 2,100.

Mr. CHRISTENSEN. 2,100, and you started this company from scratch?

Mr. WIGGINS. Yes, about a billion and a half, billion three or four this year.

Mr. CHRISTENSEN. I would just say hats off to you, Mr. Wiggins, because you are a prime example of what made this country great in terms of entrepreneurial capitalism, entrepreneurial activity, creating jobs, expanding the tax base, and you are much more than just an economist, you are the envy of America, and I appreciate your testimony here today.

Mr. WIGGINS. Thank you.

Mr. ENSIGN. He wants a job afterward.

Chairman THOMAS. No, you are going to be here for a long time, Mr. Christensen.

As one who did not vote for catastrophic, in trying to follow it, who was relatively new to the whole process, I mean, what I thought was going on was a relatively clear disconnect from people who wanted to provide something which in terms of the larger parameters, responsibility, copays made sense. But who was going to react were people who already had what we were trying to give them, by virtue of being relatively sophisticated and purchased it in the marketplace.

Mr. GRADISON. Right.

Chairman THOMAS. What they were looking for was something they didn't have, long-term care and some other areas that we should have moved. So, to me, I just saw the train wreck coming from the beginning because not that it wasn't going to be a benefit for the entire universe, the universe that was going to react, react quickly, and react negatively. The ones who ultimately tipped the balance were those who really didn't see that they were getting anything for the additional payments. That was my analysis.

Mr. GRADISON. You are absolutely right. There were large numbers of people out there who had generous health benefit plans in retirement from the Federal service and from private industry as well who felt they wouldn't get anything out of it. I think that is part of it.

If that is so, and I am inclined to agree that was one of the elements, then it calls into question the notion of a one-size-fits-all package, and my impression is that the program in the long run would be a lot better off if it offered—I mean the Federal Government should figure out what it is willing to spend, but I think the notion of offering actuarially equivalent packages and giving people some choice makes sense.

What a lot of people, I think, were saying is, We are willing to pay a higher deductible on the present benefit package if you add some outpatient prescription drugs, as an example. They can't do that today.

Chairman THOMAS. See, that is my problem. My problem is that we can't even play the game of building up the package that we now have under the old fee-for-service to continue to try to profile what is going on out there because the change is so rapid.

What I got out of catastrophic was that we ought to get out of the business as government either bureaucrats or elected officials in trying to guess what people want. Our job is to create some kind of a clear, as the best we are able with all the techniques we have, equivalency in which people vote with their feet. The Medicare check will let them vote where they want the money to go. Our job is to make sure that you have got minimum standards out there.

This is a slightly different profile group than most, but the program that will work best is the one that they choose, not the one that we choose, and that is where I think we will be able to make changes and not have it blow up on us like catastrophic did.

Are there any more questions?

I want to thank this panel very much. You obviously are very, very knowledgeable. Let me say that you are going to be relied on very heavily and others like you in shaping this program. You are out there doing it, and we need you.

Mrs. JOHNSON. Mr. Wiggins, would you reply to Mr. McDermott's question in writing for us regarding the 69-percent figure he used, and we can get that, the staff on that side, to clarify those figures, because those kinds of figures were used throughout the hearing in a number of circumstances and this committee needs to understand that when 69 percent is spent on services, that does not mean that 31 percent is spent on administrative costs or profit. So we need to get clear what dollars get spent on services, what are administration, what are costs, and what are other kinds of expenditures like those you described that were more complicated.

Thank you.

Mr. WIGGINS. I would be happy to.

Chairman THOMAS. My assumption is it won't be on Health Care Leadership Council letterhead.

[No information was received at the time of printing.]

Chairman THOMAS. We will ask for our last panel to come forward, please. Ms. Musser, Ms. Shearer, and Mr. Gauthier, we want to thank you for your patience. Any written testimony that you may have for the subcommittee will be made a part of the record, without objection, and you may proceed in any way you wish to inform the subcommittee. And we will begin with Dr. Musser.

STATEMENT OF JOSEPHINE W. MUSSER, RECORDING SECRETARY, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Ms. MUSSER. Thank you, Mr. Chairman. There is an error, it is Commissioner Musser. I am not a physician or a Ph.D., but I would like to take credit for a number of those things.

Chairman THOMAS. We will leave it up there anyway.

Ms. MUSSER. Thank you.

There are advantages and disadvantages to going on the last panel. I have pages after pages of purple ink and comments, wonderful ideas and difficult issues that were deliberated today and many very worthwhile suggestions and comments that I have written all over.

I wanted to say how impressed I am as well with the deliberation that has gone on on this very serious issue.

My name is Josephine Musser. I am the recording secretary of the NAIC, the National Association of Insurance Commissioners, and I am the Commissioner of Insurance for the State of Wisconsin.

The NAIC is the Nation's oldest association of State government officials. Our members are the chief insurance regulators of 50 States, the District of Columbia, and 4 U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to discuss the Medicare Select program today.

Mr. Chairman, I am pleased to be here today to testify in support of our position. I am also pleased to report to you that two of our sister State organizations, the National Governors Association and the National Conference of State Legislatures, join the NAIC in our position before you today.

The NAIC supports the extension of Medicare Select to all 50 States and the elimination of the sunset provision. Why? Because it is a good deal for customers. Medicare Select offers choice, it offers savings, it offers consumer satisfaction. Unfortunately, only a relatively few of our Nation's Medicare supplement customers now have this option available to them. We would like it to be available to all.

The concept of Medicare Select, of course, is quite simple. These policies are just like standardized Medicare supplement policies except that they utilize the concepts of managed care. In order to receive full benefits, Medicare Select policyholders use network providers. The policyholder's out-of-pocket expenses are larger if he or she goes outside the network for care.

Under the leadership of Governor Tommy G. Thompson, Wisconsin already had a well-established and successful managed care Medicare supplemental insurance market. With the enactment of OBRA 1990 and the Medicare Select program, we recognized that in order to maintain that market we needed to become one of the 15 States chosen to participate in the Medicare Select demonstration project. Among the others, of course, are California, Illinois, Texas, and Washington.

In Wisconsin, Governor Thompson and I are very pleased with the program. We know that the program works. We have seen the savings, and the high level of customer satisfaction Medicare Select policyholders enjoy.

During the break many of the HCFA staff members today—during the many breaks today, many of the HCFA staff members came up to me and said, We know it works in Wisconsin. If all the States would do it like Wisconsin, we wouldn't be having this discussion.

The 3-year demonstration period in the 15 States expired at the end of last year, but as you know, we have the extension for another 6 months, and so the clock is once again ticking for the Medicare supplement customers. It is time to make the program permanent and time to make it available in all States now.

When Congress instructed the NAIC to develop Medicare Select standards in 1990, we built in important customer protections. In order to sell Medicare Select policies, insurers must file a plan of operation with the insurance commissioner, demonstrating that the network provides sufficient access to care, an ongoing quality assurance program, disclosure of all network restrictions at the time of enrollment, provisions for out-of-area and emergency coverage, and the availability and cost of all Medicare supplement policies without network restrictions that are offered by that insurer.

Additionally, through 1994 and 1995, the NAIC has begun developing what has been called health plan accountability standards and model regulations, to enable State insurance departments to strengthen their quality assurance standards in the insured marketplace.

I would like to discuss that further with you, if you have questions, and also what the NAIC is doing with regards to quality assurance and especially data collection.

Our experience with Select policies in Wisconsin has been most positive. Twelve percent of our Medicare supplement market consists of Select plans. As you can see, this innovation is a substantial part of the Wisconsin market affecting thousands of Wisconsin citizens.

The consumers of my State are satisfied with their managed care Medicare supplement coverage. Over the last 5 years, only 2.2 percent of our department's Medicare supplement complaints were lodged against HMO Medicare supplement insurers.

In addition, Medicare Select coverage is cheaper, in Wisconsin a full 20 to 30 percent cheaper than indemnity products. That can be as much as $500 per year in the pocket of the average 85-year-old beneficiary.

In Wisconsin, Medicare Select works. On the national level, let me tell you more about why the NAIC supports the expansion of Medicare Select to all 50 States and the elimination of the program's sunset provision by pointing out what Medicare Select does for policyholders.

Again, it gives consumers choice, savings, and satisfaction. Nationally, the Select program offers premiums 10 to 37 percent below those of other supplement products. That is hardly pocket change to a consumer on a fixed income.

As for consumer satisfaction nationally, let's look at the closed complaints in 10 Medicare Select States for 1994. We found 967 complaints against non-Select policies. By comparison, Select policies logged a grand total of nine. That is nine complaints.

Again, I cannot stress strongly enough the choice Select policies offer Medicare supplement consumers. Not giving consumers in all 50 States the choice of these insurance products, or worse yet, taking these products away from the consumers in the 15 demonstration States would ill serve both our consumers and our marketplace, and likely we must consider the prices of the indemnity Medicare supplement products, would also increase if this product was removed from the market.

Mr. Chairman, I also ask you to consider the effects on current Select policyholders. If the program is not extended with no new enrollees, premiums will increase for current Select policyholders.

While they will be allowed to remain in the program without infusion of new members, premiums will increase as the policyholders grow older, resulting in premiums that would be well beyond the reach of consumers left stranded in the program. But if the program is expanded to all 50 States, we believe more carriers will be persuaded to enter the Select market.

Mr. Chairman, the NAIC supports the extension and expansion of Select to all 50 States. The Wisconsin experience has been a success, and we have high hopes for an expanded program on a permanent basis.

We look forward to working with you.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOSEPHINE W. MUSSER
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. Chairman and Members of the Subcommittee, my name is Josephine Musser. I am the Recording Secretary of the National Association of Insurance Commissioners (NAIC), and the Commissioner of Insurance for the State of Wisconsin.

The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to appear before the Subcommittee on Health to discuss the Medicare SELECT program.

NAIC supports the extension of Medicare SELECT to all 50 states and elimination of the sunset provision. I am pleased to be here today to testify in support of our position. I am also pleased to report to you that the National Governors Association (NGA) and the National Conference of State Legislatures (NCSL) joins the NAIC in our position before you today.

Today I will discuss the Medicare SELECT program generally; the experience of the State of Wisconsin as one of the states participating in the Medicare SELECT demonstration project; the savings accruing to beneficiaries with Medicare SELECT policies; the high level of consumer satisfaction with Medicare SELECT policies; the added choice the existence of these policies gives to Medicare beneficiaries; and the adverse effect the sunset of the program would have on Medicare beneficiaries. I will also discuss the fact that Medicare SELECT policies are supplemental insurance products and cannot be compared to Medicare Risk contracts.

Medicare SELECT

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) limited the sale of Medicare Supplement, or Medigap, insurance policies with managed care or preferred provider component to 15 states for a three year demonstration period. (The three year period expired on December 31, 1994, and, in the fall of 1994, Congress extended the program for another six months through the Social Security Act Amendments of 1994). OBRA 1990 also provided for standardization of Medigap policies. Pursuant to that legislation, the NAIC adopted the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (NAIC Model) that was incorporated into federal law when the Secretary of the Department of Health and Human Services (Secretary) published this model. This model developed 10 standard Medigap policies, A through J, and set forth the Medicare SELECT standards. Medicare SELECT policies are just like standardized Medigap policies, except that full benefits are paid only when network providers are used.

The Secretary established guidelines for states to request to participate in this demonstration project. The Secretary initially chose the following states for the demonstration project: Alabama; Arizona; California; Florida; Indiana; Kentucky; Michigan; Minnesota; Missouri; North Dakota; Ohio; Oregon; Texas; Washington; and Wisconsin. Oregon and Michigan ultimately withdrew from the project due to lack of interest by insurers, and were replaced by Illinois and Massachusetts.

OBRA 1990 established the minimum requirements for Medicare SELECT policies and the NAIC Model served as the vehicle to implement these requirements. In order to sell Medicare SELECT policies, insurers must file a plan of operation with the insurance Commissioner demonstrating that: 1) the network offers sufficient access to care; 2) the network has an ongoing quality assurance program; and 3) the insurer provides disclosure, at the time of enrollment, of the network restrictions, provisions for out-of-area and emergency coverage and the availability and cost of all Medicare supplement policies without network restrictions offered by the insurer. The plan of operation must also outline certain required disclosures to consumers including descriptions of the network restrictions, the grievance procedure and quality assurance.

As stated above, Medicare SELECT policyholders must avail themselves of network providers designated by the insurer (except for emergency services) in order to obtain full benefits under the policies. This is the main characteristic differentiating SELECT from non-SELECT Medicare supplement policies, whose policyholders have no such provider restrictions. Under both types of policies, Medicare pays a significant portion of a bill irrespective of the provider chosen by the policyholder, but the policyholder's cost-sharing portion will be larger if a SELECT policyholder obtains services outside the network.

A Congressional Research Service Report for Congress on this program estimates that as of October, 1994, 450,000 persons were enrolled in Medicare SELECT.

In all states except Massachusetts, Minnesota and Wisconsin, the Medicare supplement policies conform to the standardized A through J NAIC model plans. This is also true for SELECT policies. Massachusetts, Minnesota and Wisconsin were granted a waiver from the standardization requirement because they had standardized programs in place prior to the NAIC models. In those states, the SELECT policies must conform to the existing state standardization requirements.

The Wisconsin Experience

Managed care medicare supplement coverage has not been a stranger to Wisconsin. Well before the enactment of OBRA 1990 and the establishment of the Medicare SELECT demonstration project, Wisconsin already had a good portion of its Medicare supplement insurance market in private managed care (HMO) insurers. Since OBRA 1990 prohibited the sale of private managed care Medicare supplement insurance, except as Medicare SELECT, it was vital that Wisconsin be one of the 15 states in the Medicare SELECT demonstration project.

At the end of 1993, there were 321,336 Medicare supplement insurance policies in force in Wisconsin. The number of HMO Medicare supplement insurance policies (SELECT) in force at the end of 1993 was 41,016, or 12% of the total market. This figure includes 12,430 enrollees in Health Care Prepayment Plans. As you can see, managed care Medicare supplement coverage is a substantial part of Wisconsin's Medicare supplement market and affects many thousands of Wisconsin citizens.

Wisconsin consumers are satisfied with their managed care Medicare supplement coverage. The Wisconsin Office of the Commissioner of Insurance receives about 9,500 written consumer complaints annually for all lines of business. In the last five years, the office received a total of 1,984 medicare supplement insurance complaints, of which only 45 or 2.2% were complaints against HMO Medicare supplement insurers. Clearly, managed care Medicare supplement insurance has been a well-received, successful product in Wisconsin.

In Wisconsin, HMO Medicare supplement insurance or Medicare SELECT coverage is cheaper than indemnity Medicare supplement coverage. Depending on age and geographic location, Medicare SELECT policies are 20% to 30% cheaper than indemnity Medicare supplement policies. That can be a savings of as much as $500 per year, on average, for an 85 year old beneficiary,.

As I mentioned earlier, Wisconsin had an active HMO Medicare supplement market well before OBRA 1990 and its Medicare SELECT demonstration project. Wisconsin's market was comprised of federally sponsored programs such as Health Care Prepayment Plans and Medicare Risk policies, and private HMO Medicare supplement plans. We have actively regulated the private HMO Medicare supplement plans and the supplement portion of the federal programs. In fact, many of the provisions currently a part of the Medicare SELECT requirements were already in place as part of Wisconsin's regulatory framework for managed care Medicare supplement coverage. From Wisconsin's standpoint, we would hope that Congress would at least see fit to extend Medicare SELECT to all 50 states and eliminate the sunset provision. Without such action, more than 28,000 Wisconsin citizens would be placed in a very costly position.

Extension of Medicare SELECT to all 50 States

NAIC supports the expansion of Medicare SELECT to all 50 states, and the elimination of the program sunset provision. As you know, Representatives Johnson and Pomeroy and Senator Chafee have introduced legislation which would do just that. For a number of reasons, we strongly support these efforts.

I would like to point out what Medicare SELECT does for SELECT policyholders. The primary reason the NAIC supports the extension and expansion of the Medicare SELECT program is due to the savings it offers to the beneficiary. As stated earlier for Wisconsin, and now nationally, various sources have indicated that across the demonstration states the SELECT program offers premium savings to Medicare beneficiaries ranging from 10% to 37% off of the cost of premiums for other supplemental products. That is a significant amount of money to persons on a fixed income.

Second, there is a high degree of consumer satisfaction among SELECT policyholders. The statistics I proffered earlier regarding the extremely low occurrence of consumer complaints regarding the SELECT product in Wisconsin have been replicated among the demonstration project states. In fact, ten Medicare SELECT states, Arizona, California, Florida, Illinois, Indiana, Kentucky, Missouri, North Dakota, Texas, and Wisconsin report Medicare supplement complaints to the NAIC's Complaint Data System. Of the records received so far for closed complaints in 1994, only nine are against Medicare SELECT policies and 967 are against non-SELECT Medicare supplement policies.

Third, the existence of the SELECT product offers Medicare beneficiaries a choice among the array of Medicare coverage options, particularly since it is the only Medicare supplemental product that incorporates elements of managed care. Options currently available to Medicare beneficiaries include Medicare Risk and Cost Contracting programs, which provide non-supplemental and supplemental benefits. For supplemental coverage, beneficiaries can choose between standardized Medicare SELECT and nonrestrictive Medigap policies. Thus, Medicare SELECT creates an additional option among the entire spectrum of available options relating to Medicare and Medicare supplemental coverage.

There are also several points that need to be made about the effect on current SELECT policyholders of not extending the program. If the program sunsets, no new enrollees will be allowed in the program and premiums will increase for current SELECT enrollees. While current policyholders will be allowed to remain in the Medicare SELECT program, without the infusion of new members, premiums will increase as the policyholders age, reflecting the increased adverse experience of the aging policyholder base. It is likely that ultimately the premium will become unaffordable for persons stranded in the program (the premium "death spiral"), and policyholders could be forced into the indemnity Medigap insurance market, and be otherwise uninsurable.

Another problem which could occur if the Medicare SELECT program is not extended is that the SELECT provider networks would likely deteriorate. If there are no new members in the SELECT program, providers who decide that it is not worth the administrative burden to participate in a program which is not enrolling new members could drop out of the SELECT network. This could result in a collapse of the network and immediate loss of services to beneficiaries if there are no contracted providers to deliver care.

Some have expressed disappointment that more insurance carriers are not participating in the Medicare SELECT program. However, the lack of insurer participation may be attributed to the finite nature of the demonstration project. Many carriers were reluctant to enter the market with a new product when the market was limited to 15 states and the product might be terminated after three years. Most carriers believe that it takes two to three years to develop a product, price it, and obtain regulatory approval, and four to five years to obtain good data on the new product. It is entirely possible that with the extension and expansion of Medicare SELECT to all 50 states and the elimination of the sunset provision, more carriers will enter the SELECT market.

Now I would like to talk briefly about what Medicare SELECT is not. It is not the Medicare Risk program. Medicare SELECT is a Medigap policy - a supplemental insurance product. That fact needs to be underscored to prevent inappropriate comparisons with other managed care options available to Medicare beneficiaries. For example, standards and expectations applicable to Medicare Risk contracts, which affect the full spectrum of services received by Medicare beneficiaries, are not necessarily transferable to the Medicare SELECT program, a supplemental insurance product designed to pay benefits relating to gaps in Medicare coverage.

One of the goals of the Medicare SELECT program is to introduce the Medicare beneficiary portion of the population to concepts of managed care. It is important to note that managed care is in different developmental stages throughout the states, and is not as developed elsewhere as it is in states like Wisconsin and California. However, the introduction of the concept of managed care to Medicare beneficiaries is being achieved in the SELECT population by use of HMOs, such as in Wisconsin, and by the use of preferred provider organizations with contracted networks of providers in other states. In many areas of the country, a Medicare Risk contract is not an option for a Medicare beneficiary. If the intent in the long run is to make a transition of all Medicare beneficiaries into the Medicare Risk or similar Medicare managed care program, it well serves that purpose to have Medicare SELECT available to those portions of the Medicare population where Medicare Risk is currently unavailable to introduce them to elements of managed care.

Conclusion

The NAIC supports the extension and expansion of Medicare SELECT to all 50 states. Certainly, Wisconsin considers managed care Medicare supplement coverage and its Medicare SELECT demonstration project to be a success, and has high hopes for the program as a whole. The task of introducing the Medicare population to managed care is certainly worthwhile but will take time. Medicare SELECT is a product which we believe provides meaningful Medicare supplement coverage, helps in introducing Medicare beneficiaries to managed care and saves beneficiaries money.

We look forward to working with you on this issue. Again, thank you for the opportunity to testify.

Chairman THOMAS. Thank you, Ms. Musser.

I will ask members of the panel, do you want to try to vote and come back or get another witness in?

Ms. Shearer, you are under the gun.

STATEMENT OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, WASHINGTON OFFICE, CONSUMERS UNION

Ms. SHEARER. I will be very quick.

Consumers Union appreciates the opportunity to present our views on the issue of Medicare Select. We have spent many years monitoring the Medigap market and working to improve protections for seniors who buy Medigap policies. We worked in support of this subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA 1990 Medigap reforms. These reforms made it much easier for consumers to comparison shop among so-called Medigap policies which are designed, of course, to fill in the gaps left by Medicare.

This testimony addresses one aspect of the Medicare supplement insurance market: Medicare Select. We believe there are several major problems with the Medicare Select market, and we urge caution when it comes to making it a permanent program.

The first problem is pricing games. Medicare Select policies offer cheaper premiums to begin with, but because of a system of so-called attained age pricing that many policies use, the premiums will rise steeply as the policyholder gets older. Most of the top-rated Medicare Select policies rated by Consumer Reports were attained age rated products. Congress should not lock in or expand a program which perpetuates this deceptive pricing practice.

Second, illusory cost savings. Medicare Select premiums are often low but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other Medigap policies are designed to pay, but the hospital still has to cover its costs. The result? It shifts costs to other patients and their insurers. To paraphrase Congressman Gradison who addressed cost shifting in the Medicare market, Medicare Select, by cost shifting, represents a tax on non-Medicare Select consumers.

Third, the Medigap maze. The whole idea behind OBRA 1990 Medigap reforms was to allow consumers to make kitchen-table comparison among plans, but the Medicare Select program doesn't forward this goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

We believe that it is premature to expand or make permanent the Medicare Select program. The preliminary analysis of this program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers.

Therefore, we recommend, quickly, that Congress require all States to do what several States have done already—community rate their Medigap market to eliminate this hazardous pricing structure used by many Medicare Select plans and thereby level the playingfield among insurers. Alternatively, condition a State's ability to participate in Medicare Select to a statewide requirement of community rating for the Medigap market.

Second, require a 6-month open enrollment period for all consumers who were previously enrolled in Medicare Select who want to switch to a fee-for-service plan.

And third, limit the extension of Medicare Select to a 2-year time period that would allow for study and analysis of cost savings and quality control.

Postpone expansion of the program to additional States until the studies are complete and regulatory adjustments can be put in place. We were pleased to hear that Congressman Pomeroy spoke in support of this possibility to allow for fine tuning.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings but merely shifts the costs to other consumers. Few insurers and few consumers have participated.

In many States' regulation of this product, Medicare Select has fallen between the cracks of different regulatory agencies, leaving consumers without the protections that they need.

Congress should not expand the program and make it permanent, but should take steps now to fix what is broken, specifically the pricing structure and the need for open enrollment, and await further study results before locking the program into place.

With respect to Medicare Select, we urge you to proceed with caution.

Thank you very much for considering our views.

[The prepared statement and attachment follow:]

TESTIMONY OF GAIL SHEARER
CONSUMERS UNION

Consumers Union[1] appreciates the opportunity to present our views on the issue of Medicare Select. We have spent several years monitoring the medigap market and working to improve protections for seniors who buy medigap policies. We worked in support of this Subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA-90 medigap reforms. These reforms made it much easier for consumers to comparison-shop among so-called medigap policies, which are designed to fill in the gaps in coverage left by Medicare. We continue to believe that these reforms serve as a valuable model for future legislation in areas such as long-term care insurance and regulation of a supplemental market in future health reform.

This testimony addresses one aspect of the Medicare supplement insurance market -- Medicare Select. Medicare Select is a cross between traditional Medicare supplement (or medigap) policies and HMO's. In return for initially cheaper premiums, consumers agree to obtain care within a designated network of doctors -- in order to be reimbursed for the costs covered by the policy. (Medicare still provides coverage, regardless of whether the provider is in the Select network.)

We believe that there are several problems with Medicare Select. In the big picture, Medicare Select represents a diversion from the tough issue of reining in Medicare costs -- through managed care or other steps. Pressing questions that this Subcommittee must address include: to what extent do HMO's -- which limit seniors freedom of choice of doctor -- truly save costs (or merely select the healthy risks)? Is there adequate quality assurance in Medicare risk contracts? Is there sufficient ability for consumers who do not feel well-served by Medicare HMO's to pick up traditional Medicare/medigap coverage? Is it possible -- and fair to seniors -- to ratchet down the Medicare budget without achieving cost control in the private insurance sector (in the context of overall health care reform)?

There are several major problems with the Medicare Select market and we urge caution when it comes to making Medicare Select a permanent program:

- **Pricing games**: Medicare Select policies often offer cheaper premiums to begin with. But because of a system of so-called "attained age" pricing that many policies use, premiums will rise steeply as the policyholder gets older. Congress should not lock-in or expand a program which perpetuates this deceptive pricing practice.

- **Illusory Cost Savings:** Medicare Select premiums are often low, but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other medigap policies are designed to pay. But the hospital still has to cover its costs. The result: it shifts the cost to other patients -- and their insurers.

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[1] **Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.**

- **The Medigap Maze:** The whole idea behind the OBRA-90 medigap reforms was to allow consumers to make kitchen table comparisons among plans. But the Medicare Select program doesn't forward that goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

SUMMARY OF RECOMMENDATIONS

We believe that it is premature to expand or make permanent the Medicare Select program because of these problems and others described below. Preliminary analysis of the program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers. We recommend that Congress:

- Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a state-wide requirement of community rating for the medigap market.
- Require a six-month open enrollment period for all consumers who were previously enrolled in Medicare Select.
- Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

We elaborate on our concerns and recommendations below.

ANALYSIS OF THE MEDICARE SELECT MARKET

Pricing Games

Medicare Select policies often use an "attained age" pricing structure, which Consumer Reports says is "hazardous to policyholders." Various letters and comments regarding Medicare Select have noted that Consumer Reports found that eight of the top 15 Medigap products were Medicare Select. But this tells only part of the story. Five of the eight policies mentioned use an attained-age pricing structure. Consumer Reports stated that:

> Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable--just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5000 more than the buyer of the United American policy.[2]

The attained-age pricing structure allows companies to bait consumers with low premiums in early years, and then trap them with high increases in later years. Standardization of the medigap market resulted in price conscious consumers, with the effect of facilitating a trend away from community-rated policies and toward attained-age rated policies. The percent of Blue Cross-Blue Shield affiliates, for example, that sell attained-age policies grew from 31 percent in 1990 to 55 percent in 1993.

Ten states have recognized this market dynamic and have taken steps to protect consumer either by requiring community rating for this market or by banning attained-age rating. These are Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. Four of these states -- Florida, Massachusetts, Minnesota and Washington -- are part of the Medicare Select demonstration program.[3]

Recommendation: Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a state-wide requirement of community rating for the medigap market.

Illusory Cost Savings

The purpose of Medicare Select was to cut health care costs through coordinated care networks that increase the use of utilization review and management controls, often through PPO's. It was expected that enrollees would be restricted to a subset of providers. But the experience shows that often there is no restriction of providers. There is little coordination or management of care in Select plans.[4]

Medicare Select premiums may be low for the wrong reasons -- because these policies shift costs to others by not covering all the costs that traditional medigap policies must cover. Medicare Select companies often negotiate with providers to eliminate the payment of Part A deductibles. Insurers have indicated that the discounts of the Part A deductible by participating hospitals is the most significant source of premium savings available in Medicare supplements.[5] This means that hospitals get less reimbursement from Medicare Select carriers. It does not mean that the hospital's costs are lower, so cost shifting to other patients (and their insurers) is inevitable.

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[2] "Filling the Gaps in Medicare," Consumer Reports, August 1994, p. 526.

[3] It is premature to evaluate the impact of the combination of Medicare Select and community rating, since two states (Massachusetts and Washington) are new to Medicare Select and since community rating requirements are fairly recent.

[4] "Evaluation of the Medicare SELECT Amendments -- Case Study Report, RTI Project No. 32U-5531, prepared for Office of Demonstrations and Evaluations, Health Care Financing Administration, U.S. Department of Health and Human Services, February 10, 1994, RTI, p. XX-3.

[5] RTI, p. xi.

Before extending Medicare Select to additional states (or for a substantial time period), we urge you to study further why Medicare Select premiums are often low. Are they cutting premiums for their policyholders merely by shifting costs to other payers? Another issue of concern to us is whether the Medicare Select markets in each state are truly competitive. We understand that in California, for example, there is only one key Medicare Select carrier (Blue Cross).[6] A study prepared for HCFA found that three-fourths of Medicare Select enrollees have policies from affiliates of three Blue Cross and Blue Shield plans (in Alabama, California and Minnesota), hardly an indication of a truly competitive marketplace.[7] We urge you to study the level of competition in this marketplace, recognizing of course that traditional medigap policies do compete with Medicare Select policies.

Recommendation: Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

Medigap Maze

A key goal of the medigap reform legislation that was included in OBRA-'90 was to provide true consumer choice of medigap policy by standardizing policies, thereby simplifying the choice. In light of the minimal role the Medicare Select products have made in this marketplace, we question whether the expanded complexity offers consumers significant benefits. Consumers (in Medicare Select states) must decide between Medicare only, Medicare risk plans, Medicare cost plans, health care prepayment plans, Medicare Select plans, and traditional Medicare supplement policies. They can't even consider which of 10 standard packages to consider until they have made this choice.

Furthermore, insurers have indicated that the 10 standard medigap plans are appropriate for fee-for-service (traditional) medigap policies, but not for network Medicare Select products.[8] If Medicare Select necessitates an additional one or more standard policies, then simplicity is further undercut.

Need to Await Study Results

Medicare Select was included in OBRA-90 medigap reform legislation as a demonstration program. Medicare Select was established with the hope of achieving goals such as reducing health care costs (both for the Medicare program and consumers) and reducing the paperwork burden on consumers (since Medicare Select plans relieve consumers of the paperwork burden inherent in filing claims). It should not be made permanent until studies of its effectiveness have been completed. The preliminary report (February 1994) paints a picture of Medicare Select that is hardly complimentary. A tiny percent of people eligible have enrolled; a small fraction of insurers participate; cost savings appear to be superficial only and may be cost-shifting in disguise; the market is highly concentrated; Medicare Select regulation often falls between the cracks in state regulatory departments.

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[6] Three other plans: Foundation Health Plans; National Med; and Omni Health Plan have been approved but had minimal enrollment, that totals less than 500. [RTI, p. IV-17]

[7] p. ix.

[8] RTI, p. xiii.

Some specific findings that should set off alarms to put on the brakes -- not rush ahead with a permanent expansion -- include:

- Some states (e.g., Arizona) have found that market response has been poor and that beneficiaries tend to migrate back to traditional plans.[9]
- Several states that were selected for the program could not get it off the ground and dropped out.[10] Others have had no applications for Select plans.[11]
- When studied by RTI, only 2.5 percent of eligible Medicare enrollees selected Medicare Select policies, and most of these "rolled over" from pre-standardization products. It appears that consumers are not, in general, attracted to Medicare Select policies.[12]
- Nor are insurers attracted to the Medicare Select product: only ten percent of HMOs and medigap insurers in Select states offer Medicare Select policies, with even interest in some states.[13]

Recommendation: Congress should delay expanding and making permanent the Medicare Select program until further study results are available. It should not be made permanent without fixing the elements that are broken.

Regulatory Gaps

Medicare Select is fraught with questions about regulatory authority. It is not unusual for a state's insurance department to regulate fee-for-service medigap coverage, but another state department (e.g., Department of Public Health or Department of Corporations) to regulate Select products. It is very possible that Medicare Select policies get lost in the regulatory cracks where authority for traditional insurance and HMO's is split. This confusion has even led to approval of plans (as Select) that deviate from the OBRA '90 standard plan designs.[14]

Medicare Select consumers need regulatory protection. For example, consumers switching out of Medicare Select need protection. Consumers who choose a Medicare Select option must use providers in the designated network in order to get medigap coverage. The NAIC model regulation provided protection to consumers who elect Medicare Select but then wish to change to traditional medigap policy. Companies were required to offer such consumers a policy with similar benefits, without underwriting. **But this provision has a loophole** -- consumers have no assurance of such an offer if the

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[9] RTI, p. III-6.

[10] E.g., Oregon and Michigan. RTI, p. XV-1.

[11] E.g., Illinois. RTI, p. XV-3.

[12] RTI, p. ix.

[13] RTI, p. ix.

[14] See, for example, RTI, p. IV-9, IV-10.

Medicare Select company does not offer a traditional ("fee-for-service") medigap policy.

In the event that Congress decides to end the Medicare Select program, either now or in the future, then consumers who have Select policies when the program is ended will need protection. Without new entrants in their pool, their premiums (in closed blocks of business) would spiral upwards. They will need the protection from such an open enrollment period.

Recommendation: Congress should require that all policyholders who wish to switch out of Medicare Select be eligible for an open enrollment period (regardless of which company they select) in order to protect them against being locked into a Medicare Select plan that they do not like.[15] This protection would actually help to promote the Medicare Select option because consumers would have a safety valve if they are dissatisfied. If Congress chooses to end the Medicare Select program, insurers should be required to extend an open enrollment period to Medicare Select policyholders. We urge the Congress to study carefully the regulatory experience and analyze where regulatory authority for Medicare Select is best housed.

Does Medicare Select Compromise Quality?

Medicare Select policies keep premiums low by negotiating lower reimbursement schedules with providers (mostly hospital), providing discounts to policyholders. On average Medicare pays doctors and hospitals about 59 percent of what private insurers pay for the same services. If (in the future) Medicare Select coverage is negotiated downward (e.g., providing Select policies with Part B discounts also), providers will get even less. At some point, the cumulative impact of lower reimbursement has got to have an impact on quality of care that patients receive. This could occur when providers withdraw from providing services to consumers, or when they cut corners (such as patient time) due to the lower reimbursement levels.

Recommendation: Congress should study the impact of further negotiated discounts for providers before rushing to extend the Medicare Select program.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings, but merely shifts costs to other consumers. Few insurers and few consumers have participated. In many states, regulation of this product has fallen between the cracks of different regulatory agencies (is it insurance or managed care?), leaving consumers without the protections they need. Congress should not expand the program and make it permanent, but should take steps now to fix what is broken (the pricing structure, the need for open enrollment) and await further study results before locking the program into place. With respect to Medicare Select, we urge you to proceed with caution.

Thank you for considering our views.

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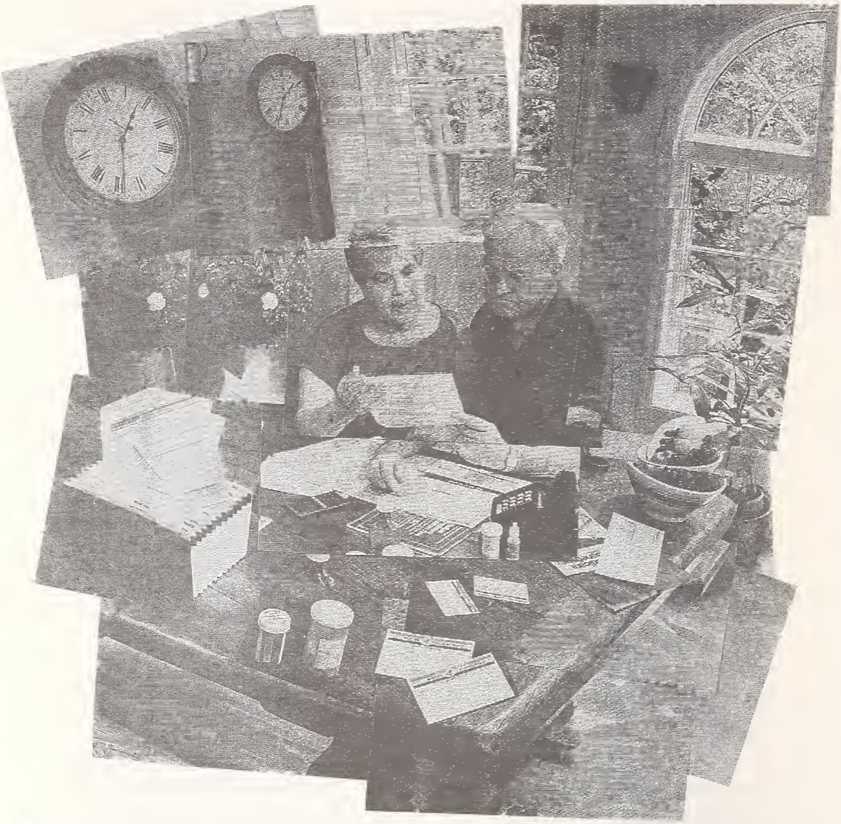
[15] In Florida, Select insurers are required to offer at least a basic Plan A in a non-Select form, providing partial protection for people who wish to switch out of Select plans. One side-effect: this provision makes it infeasible for HMO's to offer SELECt plans.



Photos by Tracey Kroll

FILLING THE GAPS IN MEDICARE

How to buy the right Medicare-supplement policy at the right price.

Some 2 million Americans will turn 65 this year and become eligible for Medicare. If you or someone close to you are among them, this report will help you understand the jargon and get the best coverage for your needs.

Since its introduction in 1967, Medicare has been a lifeline for older Americans, paying about 90 percent of their hospital and doctor bills. To handle the remainder and some other expenses Medicare doesn't cover, many people buy Medicare-supplement insurance, sometimes referred to as a "Medigap" policy.

As important as the Medicare program has become, many recipients still don't understand how it and Medicare-supplement insurance work. That ignorance has allowed some insurance companies and some doctors to take advantage of Medicare beneficiaries and the system itself.

In this report, we rate 181 Medicare-supplement policies. Next month, we'll look at the future of the Medicare program, at the managed-care options available for beneficiaries, and at policies for people with disabilities.

Five years ago, when CONSUMER REPORTS investigated the Medicare-supplement market, we found many problems, particularly in the way policies were being sold. A year after that report was published, Congress passed reforms designed to make shopping for a Medicare-supplement policy easier and to stop agents from selling duplicate policies that consumers didn't need.

What reform accomplished

The reforms resulted in 10 standard policies that were identical from company to company. The idea was to create a fairer marketplace and to make policies easier to compare. In theory, insurers would then compete to offer the lowest price for each of the 10 options.

The law has had positive effects. It eliminated the bewildering variety of benefits that insurance companies had been selling. It made agents wary of selling a prospect more than one Medicare-supplement policy, a useless and costly duplication of coverage. And it led to the creation of shopping guides in two-thirds of the states.

But a recent, seven-month investigation by CONSUMER REPORTS reveals that insurance companies and agents have in many instances thwarted the best intentions of Congress.

- Instead of offering a choice of 10 policies, agents and insurance companies are steering consumers to only one or two plans, while strongly disparaging the others.
- Agents are failing to give their sales prospects the price information they're required by law to provide.
- Agents are still urging consumers to buy benefits they don't need, and their sales pitches are as misleading as ever. One California woman who counsels seniors about Medicare sat through several agents' sales presentations with our reporter and left shaking her head. "Now I understand why they come into my office so confused," she said.
- Insurance companies are still playing pricing games that will mean nasty surprises for policyholders later on. Different insurance companies charge premiums that vary by hundreds of dollars for the same set of benefits in the same city. Our analysis of their premiums shows that many insurers charge substantially more for their policies than appears warranted.

The 10 plans

In 1992, the National Association of Insurance Commissioners created the 10 standardized plans. It is illegal for a carrier to sell anything other than those 10 plans, except in Massachusetts, Minnesota, and Wisconsin. Those states already had similar laws on the books when the Federal standards were passed.

All 10 plans, designated by the letters A through J, provide certain "core" benefits: They pay the patient's share of the cost for long hospital stays, the patient's share of the cost for physicians' services, and the cost of up to three pints of blood. (Medicare covers transfusions above that amount.) Plan A offers only the core coverage. The others provide the core plus a combination of other benefits. The chart below shows what each plan provides and explains the basic mechanics of Medicare.

State regulations require insurance agents, as well as companies that sell policies through the mail, to present an outline of the benefits in each of the 10 plans, along with price information for each plan they sell. (Insurers are not required to sell any specific plan except Plan A.) But even those fairly lenient measures are being stymied.

We sat in on agents' sales pitches in California, Florida, Maryland, and New York. Sometimes the agents didn't give their prospects the required outline—or if they did, they used it as a sales tool to disparage the plans they didn't want to sell. Half of the agents whose pitches we heard didn't leave the required price information.

Companies selling through the mail may not do much better. For example, a Physicians Mutual mailing to a consumer in Nebraska gave price information only for Plans A and F, omitting prices for the other two plans the company can sell in that state.

The goal of standardization was to allow consumers to pick the plan most suitable to their needs. But judging by the sales pitches we heard and by the sales data provided by the insurance companies, it seems that consumers are being steered primarily to only two of the 10 plans: Plan C and Plan F. About two-thirds of Medicare-supplement sales for the companies in our study come from those two plans.

Why Plan F?

Plans C and F, the darlings of the insurance industry, are nearly identical, but Plan F is particularly attractive to insurers. It differs from Plan C in that it covers excess physicians' charges—the amounts doctors can bill patients above Medicare's approved charge.

Until recently, doctors had carte blanche to sock patients with high excess charges, a practice known as "balance billing." Horror stories about balance billing have made Plan F an easy sell to consumers. But excess charges are increasingly a thing of the past.

Most patients don't encounter excess charges today, and insurers seldom have to pay off on that benefit—making Plan F a no-lose proposition for them. The average premium for Plan F runs about $160 more—in some cases $500 more—than Plan C. Yet we estimate the average value of the extra benefit at only $53.

In 1989, we did find that excess charges were a significant problem, and we recommended that people buy insurance to cover them. But since 1991, Congress has steadily reduced the amount that doctors may legally bill above Medicare's approved charge. Today they can charge their patients a maximum of 15 percent more than the approved amount. For instance, a doctor in Manhattan who balance bills for an

WHAT THE POLICIES COVER

This table shows the benefits each of the 10 plans provide. Medicare Part A covers hospital services; Part B, physician services. Medicare has an approved charge for each procedure, which varies from state to state and sometimes from region to region. Medicare pays 80 percent of that charge, beneficiaries pay the remaining 20 percent.

	A	B	C	D	E	F	G	H	I	J
Part A hospital coinsurance days 61-90 ($174 per day)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A hospital coinsurance, days 91-150 ($348 per day)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
All charges for extra 365 days in hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A blood deductible, 3 pints	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance (20% of approved charges)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled-nursing facility coinsurance, days 21-100 ($87 per day)			✓	✓	✓	✓	✓	✓	✓	✓
Part A deductible ($696 per year)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency care in foreign countries			✓	✓	✓	✓	✓	✓	✓	✓
Part B deductible ($100 per year)			✓			✓				✓
Part B excess charges						✓	✓		✓	✓
At-home care needed after an injury, illness, or surgery				✓			✓		✓	✓
Prescription drugs								✓	✓	✓
Preventive medical care					✓					✓

"intermediate office visit" (longer than a brief visit but shorter than a comprehensive one) can charge a maximum of $44.08—$38.33 plus an excess charge of $5.75 billed to the patient.

Some 65 percent of all doctors have signed "participation" agreements, meaning they will take Medicare's approved charge as payment in full for every patient. In Medicare-speak, they "take assignment." In return, they are entitled to receive 100 percent of the approved charge as their fee. (Medicare pays 80 percent; the beneficiary pays 20 percent.) For nonparticipating doctors, Medicare pays only 95 percent of the approved amount. The mathematics of balance billing give them a little over 9 percent more than the approved charge.

Increasing numbers of physicians are finding it's hardly worth the trouble to balance bill. Even doctors who don't "participate" completely often take assignment on a case-by-case basis. In 1993, about 91 percent of all approved charges were taken on assignment, and that number is rising each year. (The map at right shows the risk of facing excess charges in each state.)

Even so, in state after state, people are needlessly buying Plan F. One company shared its sales strategy with us. Its agents are to present Plan F, but if there's price resistance or if competing agents have shown policies with lower prices, they are to switch to the less costly Plan C and push a long-term-care policy as well.

At a Florida sales call, our reporter witnessed an AFLAC agent urge his prospect to avoid Plan E, which offers a $120 annual benefit for some preventive care that Medicare normally doesn't cover. The agent boasted, "I know how you can go to the doctor and still have preventive care covered. If you want to go to an ophthalmologist, complain of itchy eyes." The agent also disparaged Plan D, which covers at-home recovery, steering the consumer smoothly to Plan F instead.

"Plan F buys peace of mind," an official for South Carolina Blue Cross-Blue Shield told us. The plan also buys coverage that most South Carolinians on Medicare don't need. Last year, only about 8 percent of all approved charges were *not* accepted as payment in full. To protect themselves from this low risk, South Carolinians might spend as much as $250 more a year to buy Plan F rather than Plan C. For a couple on Medicare, that means an extra $500 in annual premiums for coverage they're not likely to need. To make that $500 expense pay for itself, they would have to buy some $3800 in services from physicians who balance bill.

Scare tactics

Some agents lie outright to scare their prospects into buying Plan F. "If I could make an impression here, it's that the gap is getting bigger and bigger between what's approved and what's charged," we heard a Maryland agent tell his prospect. In fact, the gap is narrowing. In Maryland today, only about 5 percent of approved charges are not accepted by doctors as payment in full, down from about 8 percent in 1991.

If you know your own doctor will take assignment, you may have nothing to fear. So agents warn their prospects about the excess charges billed by specialists—the ultimate sales pitch for Plan F. A Maryland agent flatly said, "If you're seeking out a specialist, you can forget about them accepting what Medicare pays." And in Florida, one insurance agent told us that "a lot of doctors take assignment, but cardiologists, anesthesiologists, and radiologists won't waive the 15 percent."

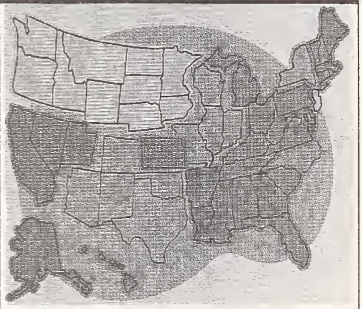
According to data supplied exclusively to CONSUMER REPORTS by the Health Care Financing Administration, which administers Medicare, that agent was far off the mark. In Florida, only 4.6 percent of approved charges from cardiologists, 1.8 percent from anesthesiologists, and 3.5 percent from radiologists were not taken on assignment, a low risk by any measure.

Nationally, most specialists, especially those who perform high-cost procedures, accept Medicare's payment as payment in full. Last year, for example, only 6 percent of all approved charges billed by cardiologists were subject to excess charges.

For anesthesiologists, the figure is somewhat higher: 10.5 percent. The risk of running into an anesthesiologist who does not take assignment is greatest in California, Colorado, Idaho, Iowa, Minnesota, Montana, Nebraska, New Jersey, New York, North Dakota, Oklahoma, Oregon, South Dakota, Washington, and Wyoming.

The doctors most likely to bill more than Medicare pays are family practitioners and internists. Nationally, about 14.5 percent of approved charges billed by doctors in family practice and a little more than 13 percent of those billed by internists were not accepted as full payment last year. But it's easy to choose a family doctor who doesn't engage in balance billing. Medicare publishes directories of participating physicians; those directories are available at local Social Security offices and from Medicare carriers listed in the Medicare Handbook sent to beneficiaries when they enroll. It's better to pick a participating doctor than to spend money for extra insurance.

WHERE THE EXCESSES ARE



Low, moderate, high If you live in one of the states colored ■, you face a low risk of running into an unassigned claim and having to pay excess charges. In those states, the percentage of such charges is below the national average of 8.9 percent. In states colored ■, your risk is moderate. In states colored ■, your risk of facing excess charges is higher—at least twice the national average.

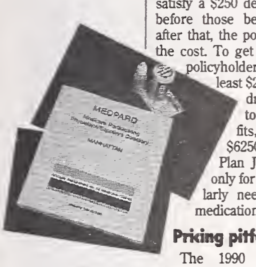
Although most Medicare services are now subject to the balance-billing limits, durable medical equipment (such as oxygen tanks and wheelchairs), prosthetic devices, and ambulance services are not. Providers of those items and services can charge Medicare patients whatever they wish. Such expenses would be covered by Plan F.

The pricey drug plans

If Plan F is oversold, Plans H, I, and J, which offer limited benefits for prescription drugs and command sky-high premiums, are hardly pushed at all. That may be a good thing. To get the $1250 maximum benefit on Plans H and I or the $3000 maximum benefit on Plan J, consumers often have to spend as much as that or more in premiums. We found annual premiums for Plan H as high as $2160; for Plan I, as high as $3088; and for Plan J, as high as $3312.

Even after shelling out such a

large premium, a policyholder must satisfy a $250 deductible for drugs before those benefits begin—and after that, the policy pays only half the cost. To get $1250 in benefits, policyholders must incur at least $2750 in prescription drug expenses, and to get $3000 in benefits, they must spend $6250. Such costs make Plan J a realistic option only for patients who regularly need very expensive medications.



Finding a doctor
To locate a doctor who participates in Medicare, check the directory found at local Social Security offices and available from the insurers that process Medicare claims.

Pricing pitfalls

The 1990 reforms of the Medicare-supplement market had another unintended effect. Many companies have changed the way they price policies so they can bait consumers with low premiums at the outset and trap them with very high increases later on.

In 1989, most carriers used either "community rates" or "issue-age rates" to price their policies. With community rates, all policyholders, young or old, pay the same premium. With issue-age rates, premiums will vary depending on the age of the buyer. But in either case, the annual premium will go up only to reflect inflation in the cost of benefits; it will not rise because you get older. Both community and issue-age rates protect policyholders from steep annual increases.

Now, however, more and more insurance companies are resorting to a less benign strategy known as "attained age" pricing. It allows companies to gain a competitive advantage by selling cheap policies to 65-year-olds when they enter the Medicare-supplement market. With attained-age pricing, the initial premiums, especially for those between 65 and 69, are usually lower than for issue-age or community-rated policies. But there's a catch: Premiums will rise steeply as the policyholder gets older.

In 1990, 31 percent of all Blue Cross-Blue Shield affiliates sold policies with attained-age rates. In 1993, 55 percent did. At the same time, the proportion of Blue Cross-Blue Shield plans offering community rates has dropped from 51 percent to 21 percent. AARP/Prudential still offers community rates but finds its initial premiums have become less competitive for policyholders age 65 to 69.

Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable—just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5000 more than the buyer of the United American policy.

Buyers are rarely warned of these consequences. Neither insurers nor agents are required to tell consumers how expensive attained-age policies will become over time. A sales brochure from California Blue Cross, which boasts one of the state's hottest-selling Medicare supplements, says nothing about rate increases; it doesn't even mention that rates are calculated on an attained-age basis. Of the 17 agents our reporter heard, only one discussed the way his company's rates were set—and he thoroughly confused the three methods. "The vast majority of agents don't understand attained-age pricing, so they can't possibly explain it to their customers," says Mark McAndrew, president of United American.

Only 10 states—Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington—either require that insurers use community rates or specifically ban attained-age policies. In most other states, insurers are shifting to attained-age policies. United American, a large seller of Medicare-supplement policies, has just notified state insurance regulators that it plans to switch from issue-age to attained-age rates. "We think attained-age rates are a bad thing, but our agents had to eat," explains Joyce Lane, a United American vice president.

Rating the policies

To obtain the prices we show in the Ratings, we asked the Blue Cross-Blue Shield organizations and the commercial carriers that do most of the Medicare-supplement business to supply us with premiums for all the plans they sell. Most cooperated; those that didn't are marked with an asterisk. If a company didn't give us its rates, we did our best to obtain them from state insurance departments. In all, we obtained more than 10,000 prices.

To judge policies, we estimated the value of benefits provided by each of the 10 plans for policyholders in 64 cities at age 65, 70, and 75. We then computed a price index for the benefits in each policy. The higher the index, the more expensive the policy.

Policyholders, of course, should expect to pay something more than the value they receive, to cover the company's expenses and provide a reasonable profit. National Association of Insurance Commissioners guidelines suggest that the extra cost for expenses and profits should not exceed 54 percent of the value of the benefits. But our analysis showed that two-thirds of the 65 companies in our survey are apparently charging more than that. Some premiums amount to nearly 150 percent of the estimated value of the benefits.

The 1990 reforms will in the future require insurers to refund money to policyholders whenever they have paid out too few benefits for the premiums they charged. If the law is enforced, many companies will be busy writing refund checks. But when we asked state regulators if they expected refunds, about half told us they did not.

Can you get a policy?

During the first six months after signing up for Medicare Part B, which covers physicians' services and hospital outpatient care, anyone can buy Medicare-supplement insurance, regardless of health, from any company. After that open window closes, companies in most states can deny coverage based on medical history. AARP/Prudential and the Blue Cross plans in some states offer "guaranteed issue" policies that provide coverage regardless of health status.

When insurers do inquire about an applicant's health after the six-month open window, they can be strict. Most ask prospective policyholders whether they've had certain health problems. A "yes" answer to any question usually triggers a rejection. Even fairly common conditions, such as having cataracts or facing surgery, can disqualify an applicant. Only a few insurers told us they would reconsider if more information were provided.

Insurance companies, including those that sell guaranteed-issue policies, are very strict when it comes to offering drug coverage. Applicants are asked to list the drugs they take and to estimate how much they spend each month. Applicants who spend more than a certain amount

OVERCHARGES, RETAINERS, WAIVERS

HOW MEDICARE PATIENTS ARE BILKED

To extract more money from Medicare patients, some physicians engage in questionable, if not illegal, practices that make patients pay more than they should. Three to watch out for are overcharges, retainers, and waivers.

Overcharges. Two years ago, James McGlynn, a 70-year-old retired truck driver from College Point, N.Y., underwent hand surgery. As a condition for performing the operation, a surgeon at a New York City hospital made him sign a contract agreeing to pay $2601.

Medicare's "approved charge" was $1243. It paid $994, its 80 percent share. McGlynn's supplemental insurer, Empire Blue Cross-Blue Shield, made the 20 percent copayment of $249. That left McGlynn with an out-of-pocket expense of $1358—$1172 of which represented an illegal overcharge. Under New York law in 1992, a doctor could charge a patient no more than an additional 15 percent of Medicare's approved charge. But McGlynn paid the bill; to him, a contract was a contract.

Last year nearly 1.5 million Medicare beneficiaries were illegally overcharged by their doctors. The overcharges totaled some $101-million.

Until mid-1992, the Health Care Financing Administration, which administers Medicare on the Federal level, had done practically nothing to enforce the laws on overcharging. In fact, it was telling beneficiaries they had to pay the illegal amounts. New York state was doing even less. Later that year, the HCFA began "looking at" excess charges doctors billed and advising them they were overcharging. In 1993, it began notifying beneficiaries they had been overcharged.

This year, the HCFA is trying to make doctors refund illegal charges to patients and show proof that they did. It's too early to judge the effectiveness of this latest activity. Though the law provides civil penalties for doctors who repeatedly overcharge and doctors can be thrown out of the program, the HCFA is just beginning to look for repeat offenders. So far, no doctors have been punished.

Medicare-supplement carriers are not required to cover any excess charges above the legal limits. However, some insurers apparently will pay even illegal charges. That often tempts doctors to see what they can get away with.

Retainers. In late May, our reporter obtained from an Atlanta physicians' office a retainer agreement obligating new Medicare patients to pay $400 for a package of services ostensibly not covered by Medicare. Those doctors require that new patients sign the agreement in order to be treated. Services include a comprehensive physical examination, an annual flu shot, a sigmoidoscopy (to examine the colon), and unlimited office and hospital visits. The package also covers the patient's Medicare Part B deductible of $100 and 20 percent coinsurance. Doctors in several states have been selling this package, called "Primary Physician Care." Similar packages have been marketed elsewhere.

According to the HCFA, these retainers may be illegal. They duplicate provisions in a traditional Medicare-supplement policy; at the very least, they duplicate coverage for the Part B deductible and the Part B coinsurance. The 1990 reforms make it a crime to knowingly sell someone a policy that duplicates benefits in a Medicare-supplement policy that person already owns. That provision was aimed at unscrupulous insurance agents who sometimes sold individuals duplicate coverage in order to boost their commissions. But it could as easily apply to unscrupulous doctors.

The HCFA has made little headway in stemming the sale of such services. It must rely on the Office of the Inspector General in the Department of Health and Human Services to bring criminal prosecutions. That office has shown little enthusiasm for upholding the law. It has said it would not even consider prosecuting a case unless it involved $100,000 or more and was clear-cut. It has also said it will not open new cases in certain parts of the U.S.

Waivers. Many doctors are asking patients to waive their right to have the doctor bill Medicare directly for his or her services. Patients may also be asked to pay separately for telephone calls, medical conferences, and prescription refills—all services Medicare considers part of the fees it pays physicians.

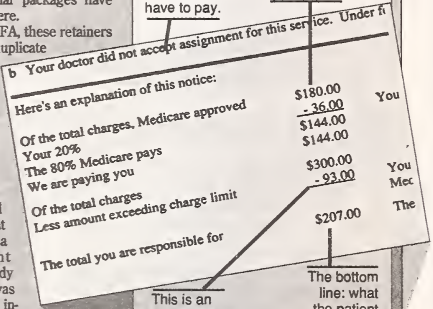
In what's called a "global" waiver, a doctor lists a number of vague categories and asks patients to pay for services that might fit into those categories. Two examples: "Medicare does not usually pay for this injection or this many injections" and "Medicare does not usually pay for such an extensive procedure."

The only type of waiver that's legal is one that lists a specific uncovered procedure such as cosmetic surgery. All others have the potential for violating the excess-charge limits. That, however, didn't stop a Manhattan osteopath from telling our reporter in late May that such a waiver would be required before he would provide services. Two years earlier, a patient had given the same waiver from the same doctor to the Medicare Beneficiaries Defense Fund, a New York-based advocacy group. Last year, the defense fund sent the waiver on to the HCFA, and a few months later the HCFA told insurance companies that pay Medicare's claims to notify doctors that such waivers could be illegal. The practice continues, nevertheless.

ANATOMY OF AN OVERCHARGE

The Explanation of Medicare Benefits that patients receive from Medicare spells out what Medicare pays and what they have to pay.

This is Medicare's approved charge for the services in question. Medicare pays 80 percent of that amount.



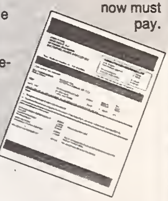
b Your doctor did not accept assignment for this service. Under f

Here's an explanation of this notice:

Of the total charges, Medicare approved	$180.00	You
Your 20%	- 36.00	
The 80% Medicare pays	$144.00	
We are paying you	$144.00	
Of the total charges	$300.00	You
Less amount exceeding charge limit	- 93.00	Mec
	$207.00	The
The total you are responsible for		

This is an illegal overcharge. The doctor has exceeded the balance-billing limit of 15 percent.

The bottom line: what the patient now must pay.



are out of luck. That threshold can be low. New York Life, for instance, refuses to sell drug benefits to anyone whose monthly prescription bill exceeds $100.

What to buy

For most people, the important benefits beyond the core are coverage for Medicare's hospital deductible, this year $696; the coinsurance required for a stay in a skilled nursing-care facility; and at-home recovery services, a potentially useful although limited benefit.

Plans B, C, and D cover most of the basics with the fewest frills. Unless you live in a state where you face a high risk of running into unassigned claims, you'll save money if you skip Plan F and its higher-priced cousins—Plans G, I, and J. The plans with drug coverage (H, I, and J) don't appear to be worth the added cost.

We have based our comparisons on Plan C—not because it's the ideal plan, but because it is one of the most widely available. Plan B is a better choice, if you can find it. It covers most of the important gaps and is about 16 percent cheaper on average than Plan C. The average annual premium runs about $722 for Plan B, compared with $856 for Plan C.

Plan D is also a better value than Plan C but unfortunately just as hard to find as Plan B. Unlike Plan C, it doesn't cover the $100 deductible for Medicare physicians and outpatient services—a benefit that sometimes adds more than $100 to the premium. Instead, Plan D covers some at-home recovery services that could be useful. A few Blue Cross organizations do sell Plan D.

The section of the Ratings titled "How the Insurers Rank Nationally" lists companies that generally have lower-than-average prices. Because our national rankings are based on all plans across all cities and all ages, they are only a rough guide. A company may sell cheaper policies in one location and very expensive policies in another.

The "Best Policies" table on the following page is specific to 64 cities. It lists the two best community-rated or issue-age policies and the best attained-age policy for each locality. Though we include attained-age policies, we don't recommend them for most people. They should be considered only by people who have reason to believe they won't live very long or who know they will have enough money to cover the steeply increasing premiums in old age. Note that, in some locations, a community-rated or issue-age policy may have a lower rate than an attained-age policy.

AARP/Prudential's community-rated policies are clearly the best buys for people 75 or older. And with the exception of the drug plans, the AARP policies have the added advantage of being available to everyone at any time. Even the AARP policies for 65-year-olds show up among the best values for some locations.

A word of caution, however. To continue community rating with competitive prices, AARP/Prudential must continue to attract its share of younger applicants. If it doesn't, it may later have to raise rates or stop offering community-rated policies.

If you have an old plan that you bought before standardization, and it covers private rooms and private duty nurses, you might want to keep it, since those benefits are no longer available. But if you can buy a cheaper plan that gives you the coverage you want, you may want to switch. If you do switch, remember the attained-age pricing trap.

You may also want to consider company stability. If your carrier got

TOUGH DECISION

EMPLOYER COVERAGE OR YOUR OWN?

When Milton Stern retired nine years ago from Smith International, a maker of oil-well valves, the company provided health insurance that cost Stern and his wife $300 a year. The policy required a small deductible—a total of $100 for both. But the Sterns' good fortune didn't last. When the company got into financial trouble, it switched its retirees to another type of plan.

Stern's premium climbed to $1500 a year, and he and his wife had to satisfy a $400 deductible. That sent Stern into the market for traditional Medicare-supplement insurance. Stern, who is 84, eventually bought coverage from AARP/Prudential, the best choice we've found for people at older ages. Its policies are community-rated and don't have medical requirements.

Stern's dilemma illustrates what thousands of retirees are facing—the loss of good supplemental coverage paid by their former employers. Hundreds of employers are cutting retiree benefits or dropping their coverage altogether.

Judging ex-employer coverage. The 1990 reforms that led to standardized Medicare-supplement policies did not apply to the coverage offered by employers. If the coverage offered by an employer is clearly inadequate and far too expensive, a retiree may want to drop it and buy a traditional Medicare supplement, as Stern did. However, if the employer's coverage provides prescription-drug benefits but is otherwise inadequate, or if a younger spouse not yet eligible for Medicare is involved, the decision is harder. In these situations, a retiree may have little choice but to keep the employer's coverage, especially if the premium is fairly low.

Can you have both? It's technically illegal for an insurer to sell a policy that duplicates benefits provided by an employer. (The 1990 reforms outlawed duplicate coverage because some unscrupulous insurers were selling consumers multiple policies.) Our survey shows that state regulators do not agree on whether this is, in fact, duplication. They need guidance from Congress. But Congress has yet to pass "technical" corrections to the reform laws that would allow employees to have both types of coverage.

If you work past 65. People who continue to work after age 65 face different choices. If you work for a company with 20 or more employees, your employer must offer you the same coverage it offers younger workers. You can take that coverage, which may be broader than Medicare's.

If you do choose your employer's coverage, you may want to delay signing up for Medicare Part B. That's because the six-month open-enrollment window (during which you do not have to meet an insurer's medical requirements) doesn't begin until you first sign up. If you sign up and don't buy a policy within the next six months, you could be out of luck. Your employer's coverage is primary in this situation anyway, and it's probably not worth the trouble to get Medicare to pay for small amounts not covered by your employer's insurance. That is especially true if your health coverage is provided through a managed-care plan, for which the copayments are likely to be small.

If you choose to sign up for Medicare instead of the employer plan, your employer is not allowed to offer a Medicare-supplement policy. You will have to buy one on your own.

If you continue to work for a company with fewer than 20 employees, the rules are different. Medicare becomes your primary insurer, and your company is allowed to provide you with a supplemental policy. But many small firms don't, and most likely you'll have to buy your own. Be sure to do so before the six-month window closes.

into financial trouble, you could look to the guaranty fund in your state to protect your benefits. Or more likely, the state insurance department would arrange for another company to take over your coverage. However, you might be inconvenienced in the meantime. For a discussion of company financial strength, see "When It's Time to Buy Life Insurance," CONSUMER REPORTS, July 1993.

Needed: Further reform

Many of the problems still afflicting the Medicare-supplement market mirror those in the larger health-insurance market. There are disturbing parallels between the disappearance of community- and issue-age rating in Medicare supplements and the demise of community rating for other types of health coverage. That trend has made insurance unavailable or unaffordable for many employees of small firms, a problem that helped create the current health-care crisis. Unless state regulators outlaw attained-age pricing or national health reform makes community rating mandatory for Medicare-supplement policies (as it would be under the Clinton health-care plan), attained-age pricing will take over the marketplace, with serious consequences to the oldest policyholders.

Some health-care reform proposals are based on the theory that market competition and the availability of information about providers and health-care plans will enable consumers to select the right coverage at the best price. Our investigation of the Medicare-supplement market indicates that those assumptions haven't been borne out. Market competition is of little help if it doesn't result in better products, better prices, or both. And information is all but useless if it never reaches the consumer it was intended to help. ■

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Best policies for 64 cities

Notes on the table This table lists the best community- or issue-age-rated policy for Plan C, a widely available plan that covers the essential gaps in Medicare. The table also shows the best attained-age policy, although such policies are inappropriate for many people, as we explain on page 526. **Premium** reflects annual premiums for community- or issue-age-rated policies at age 65; such premiums are subject to annual increases based on increases in Medicare deductibles and coinsurance, but not on the policyholder's age. Attained-age premiums are the initial premiums paid by someone at age 65; they are subject to substantial increases as the policyholder ages, as well as to increases due to higher deductibles and coinsurance."Select" policies are a combination of traditional insurance and managed-care plans, such as health-maintenance organizations. We will discuss how they work next month.

	Best community or issue-age policies				Best attained-age policy	
Location	**First company**	**Premium**	**Second company**	**Premium**	**Company**	**Premium**
Ala. (Birmingham)	Continental General	$834	AARP/Prudential	$945	Union Bankers	$586
Alas. (Anchorage)	AARP/Prudential	744	AFLAC	877	Bankers United Life	800
Ariz. (Phoenix)	Physicians Mutual	843	AARP/Prudential	846	Samaritan Group (Select)	716
Ark. (Little Rock)	AARP/Prudential	804	Pyramid Life	867	[1]	
Calif. (Los Angeles)	AARP/Prudential	963	Continental General	969	Central States Health & Life	908
Calif. (San Diego)	Continental General	862	AARP/Prudential	963	Bankers Life & Casualty	756
Calif. (San Francisco)	Continental General	862	AARP/Prudential	885	Bankers Life & Casualty	756
Colo. (Denver)	Physicians Mutual	773	First National Life	792	Union Bankers	683
Conn. (Bridgeport)	Central States Health & Life	786	Bankers Life & Casualty	885	[1]	
Del. (Wilmington) [2]	AARP/Prudential	831	Union Labor Life [3]	847	Union Bankers	384
Wash., D.C.	AARP/Prudential	717	AFLAC	888	Bankers Life & Casualty	596
Fla. (Jacksonville)	Continental Life Insurance	841	AARP/Prudential	858	[1]	
Fla. (Miami)	Continental General	990	Mutual of Omaha	1050	[1]	
Fla. (Tampa)	AARP/Prudential	858	Medico/Mutual Protective	897	[1]	
Ga. (Atlanta)	Physicians Mutual	805	Integrity National Life	818	[1]	
Hawaii (Honolulu)	AARP/Prudential	501	Continental General	842	Bankers United Life	724
Idaho (Boise) [4]	AARP/Prudential	702	First National Life	732	Pioneer Life	643
Ill. (Chicago)	AARP/Prudential	852	United American	968	Central States Health & Life	699
Ind. (Indianapolis)	First National Life	550	AARP/Prudential	693	Integrity National Life	556
Iowa (Des Moines)	AARP/Prudential	711	Continental General	742	American Republic	611
Kan. (Wichita)	Mutual of Omaha	756	AARP/Prudential	780	Hartford Life [3]	557
Ky. (Louisville)	Humana (Select)	684	Blue Cross Blue Shield of Ky. (Select)	694	Central States Health & Life	629

[1] *State does not allow attained-age rating, or no company provided attained age-rates.*

[3] *Policies unavailable to general public; sales restricted to members of particular groups.*

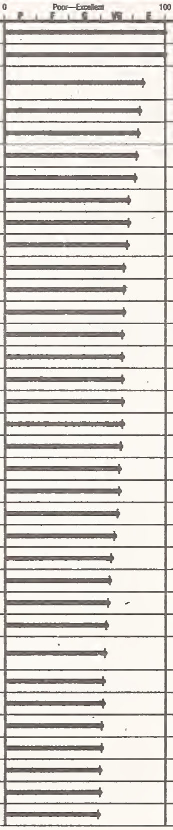
[2] *State does not allow Plan C; rates are for Plan D.*

[4] *Passed laws prohibiting attained-age rating; not yet implemented.*

	Best community or issue-age policies				Best attained-age policy	
Location	**First company**	**Premium**	**Second company**	**Premium**	**Company**	**Premium**
La. (New Orleans)	Continental General	$890	Physicians Mutual	$945	Central States Health & Life	$768
Me. (Portland)	Blue Cross Blue Shield of Maine	548	AARP/Prudential	606	[1]	
Md. (Baltimore)	First National Life	792	Union Labor Life [3]	809	Union Bankers	651
Mich. (Detroit)	United American	867	Medico/Mutual Protective	889	Union Bankers	683
Miss. (Jackson)	Continental General	801	AFLAC	877	Celtic Life	654
Mo. (Kansas City)	Continental General	810	AARP/Prudential, Equitable Life & Casualty	852	Bankers Life & Casualty (Select)	573
Mo. (St Louis)	Continental General	810	AARP/Prudential, Equitable Life & Casualty	852	Bankers Life & Casualty (Select)	573
Mont. (Billings)	AARP/Prudential	711	First National Life	732	Bankers United Life, Bankers Life & Casualty	724
Neb. (Omaha)	Continental General	732	AARP/Prudential	780	Celtic Life	594
Nev. (Las Vegas)	Standard Life & Accident	963	AARP/Prudential	969	Union Bankers	779
N.H. (Manchester)	AARP/Prudential	675	Physicians Mutual	844	Bankers Life & Casualty	596
N.J. (Newark)	AARP/Prudential	753	Blue Cross Blue Shield of N.J.	1010	Bankers Life & Casualty	756
N.J. (Jersey City)	AARP/Prudential	753	Blue Cross Blue Shield of N.J.	1010	Bankers Life & Casualty	756
N.M. (Albuquerque)	AARP/Prudential	732	American Republic	749	Bankers Life & Casualty	660
N.Y. (Brooklyn)	AARP/Prudential	936	First United American	1182	[1]	
N.Y. (White Plains)	AARP/Prudential	936	First United American	1182	[1]	
N.C. (Charlotte)	Blue Cross Blue Shield of N.C.	599	AARP/Prudential	681	Integrity National Life	618
N.C. (Raleigh)	Blue Cross Blue Shield of N.C.	599	AARP/Prudential	681	Integrity National Life	618
N.D. (Fargo)	AARP/Prudential	657	Continental General, Equitable Life & Casualty	810	Hartford Life [3]	592
Ohio (Columbus)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Ohio (Cleveland)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Ohio (Cincinnati)	AARP/Prudential	783	Continental General	855	Bankers Life & Casualty (Select)	570
Okla. (Oklahoma City)	Hartford Life [3]	690	Continental General	788	Central States Health & Life	629
Ore. (Portland)	AARP/Prudential	696	First National Life	792	American Republic	698
Pa. (Philadelphia)	AARP/Prudential	861	Physicians Mutual	959	Union Bankers	671
Pa. (Pittsburgh)	AARP/Prudential	861	Physicians Mutual	874	Union Bankers	671
R.I. (Providence)	AARP/Prudential	657	Blue Cross Blue Shield of R.I.	808	Bankers Life & Casualty	532
S.C. (Columbia)	Union Labor Life [3]	727	Continental General	766	Central States Health & Life	641
S.D. (Sioux Falls)	AARP/Prudential	762	Continental General	767	Hartford Life [3]	528
Tenn. (Memphis)	AFLAC	820	Continental General	834	Pyramid Life	662
Tex. (Dallas)	Continental General	877	Continental General	888	Bankers Life & Casualty (Select)	613
Tex. (Houston)	Continental General	877	AARP/Prudential	924	Bankers Life & Casualty (Select)	613
Tex. (San Antonio)	First National Life	792	Continental General	877	Sierra Health & Life (Select)	432
Utah (Salt Lake City)	AARP/Prudential	624	Equitable Life & Casualty	810	Bankers Life & Casualty	592
Va. (Richmond)	Blue Cross Blue Shield of Va.	744	AARP/Prudential	768	Integrity National Life	503
Vt. (Burlington)	AARP/Prudential	579	Physicians Mutual	689	New York Life	526
Wash. (Seattle)	AARP/Prudential	690	Physicians Mutual	705	[1]	
W.Va. (Charleston)	AARP/Prudential	783	Continental General	845	Pioneer Life	676
Wyo. (Cheyenne)	AARP/Prudential	642	Continental General	734	Pioneer Life	643
NONSTANDARD STATES' BASIC PLAN						
Mass. (Boston) [4]	AARP/Prudential	396	Blue Cross Blue Shield of Mass.	577	Bankers Life & Casualty	385
Minn. (Minneapolis)	Blue Cross Blue Shield of Minnesota	311	New York Life	483	[1]	
Wisc. (Milwaukee)	Continental General	458	AARP/Prudential	522	Central States Health & Life	431

How the insurers rank nationally

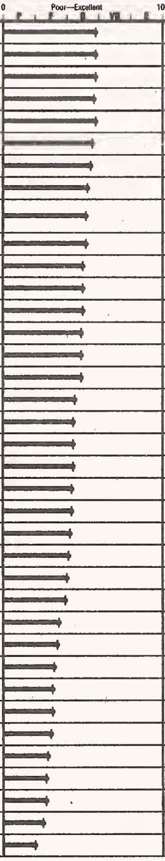
Notes on the table This table ranks the insurance companies in our study from least expensive to most expensive. For each company, we averaged the price indexes we calculated for all the plans it offers to three different age groups in 64 large cities. The "Best Policies" table on page 529 shows the policies we recommend for each of the 64 cities. If you do not live in or near one of those cities, use this table to shop for a low-cost insurer. **Value index** is based on a price index that measured the value of a package of benefits in relation to each plan's cost. **Underwriting** is our judgment of how tough a company's medical requirements are for obtaining a policy without drug coverage after the six-month "open window" has closed. **Pre-existing conditions** shows the waiting period before policyholders are covered for an existing medical problem. **Rating method** shows which of three methods the insurer primarily uses. Most policyholders are better off with a community- or issue-age rated policy. Dashes indicate information was unavailable.



Company	Value index	Underwriting	Pre-existing conditions	Rating method	Telephone
Blue Cross Blue Shield of Mich.		Guaranteed	None	Community	800 848-5101
Blue Cross Blue Shield of Minn.		Strict	None	Community	612 456-5050
Blue Cross Blue Shield of Ky., Southeastern Group (Select)		Strict	6 mo	Community	502 423-1316
Sierra Health and Life (Select)		Strict	None	Attained age	800 688-0010
Bankers Life & Casualty (Select)		Easy	None	Attained age	800 621-3724
Mennonite Mutual Aid Assn. [1]		Moderate	2 mo.	Issue age	800 348-7468
Blue Cross Blue Shield of Fla. (Select)		Guaranteed	None	Issue age	800 876-2227
Arkansas Blue Cross Blue Shield		Strict	None	Community	800 338-2312
Samaritan Group (Select)		Strict	6 mo.	Attained age	602 491-1888
Blue Cross Blue Shield Mass.		Guaranteed	None	Community	800 258-2226
AARP/Prudential		Guaranteed	3 mo.	Community	800 523-5800
Independence Blue Cross *		—	—	Community	215 241-2400
Blue Cross of Calif. (Select) *		—	—	Attained age	800 747-0548
Blue Cross Blue Shield of Ariz. (Select)		Guaranteed	None	Attained age	800 543-2944
First Health of Ariz. (Select)		Guaranteed	None	Community	602 933-1344
Hartford Life * [1]		—	—	Attained age	203 547-5000
Blue Cross Blue Shield of Tex.		Guaranteed	6 mo.	Attained age	800 654-9390
National Home Life (Select)		Strict	None	Issue age	800 356-6271
Humana (Select) *		—	—	Community	800 245-4446
Integrity National Life		Strict	6 mo.	Attained age	800 999-1843
Blue Cross Blue Shield of Va.		Strict	6 mo.	Issue age	800 443-6646
Blue Cross Blue Shield of Conn.		Guaranteed	6 mo.	Community	800 238-1143
Anthem Life		—	—	Attained age	214 732-2000
Blue Cross Blue Shield Illinois		Guaranteed	None	Attained age	800 624-1723
First United American		Guaranteed	2 mo.	Community	214 328-2841
Blue Cross & Blue Shield of Me.		Guaranteed	Varies	Community	800 585-0099
Central States Health & Life		Strict	3 mo.	Attained age	800 541-2363
Aid Association for Lutherans [1]		Strict	6 mo.	Community	800 225-5225 x5913
Blue Cross Blue Shield of N.C.		Moderate	6 mo.	Issue age	800 672-6584
Blue Cross Blue Shield of Ky., Southeastern Group		Strict	6 mo.	Community	502 423-1316
Blue Cross Blue Shield of La.		Guaranteed	None	Attained age	504 832-5800
Empire Blue Cross Blue Shield *		—	—	Community	212 476-1000
Blue Cross Blue Shield of Md.		Guaranteed	3 mo.	Attained age	800 544-8703
Blue Cross Blue Shield of N.J. *		—	—	Community	201 466-4000
Blue Cross Blue Shield of Ariz.		Guaranteed	None	Attained age	800 543-2944

[1] *Policies unavailable to the general public; sales limited to members of particular groups.*

* *Company refused to participate. Rates obtained from state insurance departments and other sources.*



Company	Value index	Underwriting	Pre-existing conditions	Rating method	Telephone
Physicians Mutual *		—	—	Issue age	800 228-9100
Blue Cross of Western Pa. *		—	—	Community	800 345-7806
USAA Life *		—	—	Attained age	800 531-8000
Blue Cross Blue Shield of Fla.		Guaranteed	None	Issue age	800 876-2227
Continental General		Strict	None	Issue age	402 397-3200
Union Labor Life * [1]		—	—	Issue age	800 637-7947
Pioneer Life		Strict	3 mo.	Attained age	800 759-7007
Pyramid Life		Strict	6 mo.	Attained age	913 722-1110
Blue Cross Blue Shield of Mo.		Guaranteed under 70	None	Attained age	800 366-2583
Blue Cross Blue Shield of R.I.		Guaranteed	Varies	Issue age	800 527-7290
Blue Shield of Calif.		Strict	6 mo.	Attained age	800 248-2341
Mutual of Omaha *		—	—	Attained age	402 342-7600
Blue Cross Blue Shield of Ala.		Guaranteed	6 mo.	Community	800 292-8855
Community Mutual *		—	—	Attained age	513 872-8100
Blue Cross Blue Shield of N.D. (Select)		Strict	6 mo.	Attained age	701 282-1100
Bankers United Life		Strict	6 mo.	Attained age	800 538-1019
Standard Life & Accident		Moderate	None	Issue age	405 232-5281
Union Bankers		Strict	None	Attained age	800 542-6034
New York Life		Strict	Varies	Attained age	800 995-7445
AFLAC		Strict	2 mo.	Issue age	800 992-3522
Continental Life Insurance *		—	—	Issue age	615 377-1300
Bankers Life & Casualty		Easy	None	Attained age	800 621-3724
PFL		Strict	6 mo.	Attained age	800 538-1018
Blue Cross Blue Shield of Ala. (Select)		Guaranteed	None	Issue age	800 292-8855
American Republic *		—	—	Attained age	800 247-2190
First National Life		Strict	6 mo.	Issue age	800 289-3654
United American		Strict	2 mo.	Issue age	214 328-2841
Celtic Life		Strict	6 mo.	Attained age	800 766-2525
Gerber Life *		—	—	Issue age	914 761-4404
Allianz Life of North America *		—	—	Attained age	612 347-6500
Blue Cross Blue Shield of S.C.		Strict	6 mo.	Attained age	800 444-0030
Medico Life/Mutual Protective *		—	—	Issue age	800 228-6080
Blue Cross Blue Shield of N.D.		Strict	6 mo.	Attained age	701 282-1100
Life Investors		Guaranteed	6 mo.	Attained age	800 752-9797
Medical Service Bureau of Idaho		Moderate	None	Attained age	800 632-2022
Humana *		—	—	Community	800 245-4446
Equitable Life & Casualty		Strict	Varies	Issue age	800 352-5150
Companies cooperating with survey but not selling in the areas surveyed					
Capital Blue Cross	N/A	Guaranteed	6 mo.	Community	717 255-0820
Blue Cross Blue Shield of Utica Watertown	N/A	Guaranteed	6 mo.	Community	315 798-4231
Security Health Plan	N/A	Strict	None	Attained age	800 472-2363

Chairman THOMAS. Thank you very much, Ms. Shearer.

Mr. Gauthier, if you will wait until we come back, just hold your fire. We will be back as soon as we can.

Thank you very much. The committee stands in recess until we get back from the vote.

[Recess.]

Chairman THOMAS. Mr. Gauthier, if you would begin I would appreciate it.

STATEMENT OF C. PAUL GAUTHIER, C.P.A., PRESIDENT, OLYMPIC HEALTH MANAGEMENT SYSTEMS, INC.

Mr. GAUTHIER. OK. First of all, I would like to comment that we are in support of expansion and making Medicare Select permanent in all States. And so all of the positive comments that were made before we certainly support, and I will eliminate a lot of the comments that I would have previously made because they have been so often reiterated.

First of all, I would like to tell you that Olympic Health Management Systems, Inc. is a hospital consulting company specializing in managed care products. We also act as a third-party administrator, manage insurance agencies and oftentimes we are a broker for insurance products. We have roughly 180 hospitals participating in Medicare Select products running around the country with a file of the products which we assisted our insurers filing in the States of Illinois, Indiana, Texas, Missouri, Wisconsin, Alabama, and Ohio. We have other hospitals that have supported the expansion in their States and we have three other additional States that we will be bringing on in the course of the next few months.

There are several comments that I would like to be able to make in favor of the hospitals which we represent. One thing that I think is important to recognize is that our 180 hospitals very much favor the expansion of Select. Indeed, if you look at the 180-hospital composition, we have hospitals ranging anywhere from 40-bed size to major tertiary facilities. All inclusive, our 180 hospitals represent operating expenses in their budgets of in excess of $10 billion. The combined employees for our facilities are well in excess of 140,000.

Although I don't represent the hospital industry as a whole, I think for the most part I represent our hospitals. Hospitals need this Medicare Select program because they view this as an integral part of their expanding into the Medicare risk contracts or potentially voucher systems. They embrace the concept of capitation, they are not at all concerned about being at-risk, and believe that they can help manage costs more efficiently than the way the system currently is managed under the Medicare system.

Some of the issues that I think might help to expand the Select product properly in the future is, we would like to see some provision for safe harbor for physicians. Physicians today are terrified to enter into any kind of joint venture managed care programs with or without hospitals' involvement because of the threat of losing their Medicare provider status.

The current Medicare Select statutes allow for Federal review for all Medicare Select products, and this should be sufficient to protect Medicare's interest. Physicians must be allowed to participate without the threat of losing their livelihood.

In the area of community rating, community rating a product is fine if in fact you are enrolling roughly 15 percent of new business a year. Otherwise, your business begins to age in place. What that will basically spell out in a global community rating situation without permanent adoption of Select in all the States is more and more insurers will shy away from supporting the Select product.

In the area of open enrollment, if there is ever any consideration to having an open enrollment during a 1-month period, this would probably be suicide for a Medicare Select product. A Select product needs to enroll its population month by month over time.

The problem here is that it takes well in excess of 90 days to train, supervise agents to sell this product on a one-to-one sale. You simply can't expect to have any kind of critical mass with Select if that open enrollment period is contained.

I would also like to make a case for the issue of allowing office copay visits in Medicare supplement insurance but specifically Medicare Select. Insurers must be allowed to offer small copays per visit, just like HMOs. Not only does this reduce premium, but it is critical to remind the policyholder of the per incident cost implications of office visits.

Currently, there is an innovative benefits clause in all of the Medicare Select regulations which we believe should allow for small copays per office visit, but State insurance departments do not want to interpret this regulation without Federal guidance.

I would also like to make one more case in terms of expansion of Select to all States. You really need to send a clear message to providers and insurers that managed care is endorsed by the Federal Government, and I believe that if you allow the Select to stay where it is or not give it permanent status, the message that you would be giving to providers out there, in essence, is that the Federal Government supports managed care but only on a demonstration or on a test basis, and representing the hospitals that support capitation, support the issue of case management and managing the Medicare system in a different way, I think you would do well for the hospital industry and probably the physicians as well to expand the product line.

Thank you.

[The prepared statement follows:]

C. Paul Gauthier, CPA, President
Olympic Health Management Systems, Inc.
Bellingham, Washington
February 10, 1995

Hospitals' Perspective of Medicare Select

When the Medicare program was proposed in 1966, the AMA opposed this movement on the basis that it would result in nationalized medicine. Congress softened this argument by proclaiming that reasonable fees would be paid based upon area norms and that the physician would be responsible for the direction of the quality of care provided. These promises are no longer manageable. The Medicare system was designed to insure access to healthcare for a population on fixed or limited incomes, however, in 1966, there was simply no recognition that the healthcare delivery system would be so successful at extending human life through access of technology and services. The financing problems of access and technology are now greatly compounded by the impact of the aging "baby boomer" population.

The political and social issues associated with controlling costs through access, utilization, and reimbursement will require years to retool the healthcare delivery system. Healthcare providers are genuinely concerned that the rules historically defined by government and insurers will dramatically change and, therefore, would negatively impact the quality of care. Healthcare providers are willing to assume increased responsibility on issues of access, utilization, and reimbursement, however, they have not always been provided the tools to manage the process.

HMO Medicare Risk programs have provided an opportunity for healthcare providers to influence or control issues on access, utilization, and reimbursement. HMO Medicare Risk programs have, to date, generally been limited to high cost, densely populated areas where managed care commercial programs have been in existence for several years. Medicare Select has now provided the opportunity for hospitals to assume similar leadership roles in their community without the harsh financial implications involved in a Medicare Risk program. From the perspective of hospitals, Medicare Select has provided the following critical advantages:

◊ Because deductibles and coinsurance represent by definition a small percentage of the overall cost of providing care to Medicare beneficiaries, hospitals are not as concerned about the overall risk of this managed care program. Accordingly, healthcare providers are much more willing to assume risk, work with their medical staff to optimize health care, support insurer marketing efforts, and provide innovative managed care programs.

◊ Hospitals generally do not have access to detailed utilization data to influence provider behavioral modification. Insurers who may have access to useful utilization data may not make such data available because of the proprietary nature of the data, confidentiality requirements, or the inability of extracting the data in meaningful reports. Because hospitals have formed financial relationships with insurers, they now have proprietary access to all claims information. Medicare Select allows for the opportunity of extracting data on policyholders for not only the deductibles and coinsurance, but all of the data elements extracted and adjudicated by the Medicare system. Access to such clinical information is absolutely paramount in developing optimally managed care system. Over 150 hospitals are now accessing clinical information for Part A and Part B services by engaging in crossover claims exchange with the Medicare Part A and Part B Intermediaries.

◊ During the past decade, hospitals have attempted to provide educational forums, senior membership clubs, health screening and wellness programs, in an attempt to improve the continuum of care offered to Medicare beneficiaries in their service area. A Medicare Select program interlocks the various financial components of the delivery system into a coordinated continuum of care process. All of these basic elements are necessary to execute a successful Medicare Risk program and achieve savings in the delivery system.

Medicare Managed Care Achieves Savings

The table on the following page represents an example of the potential savings in per capita monthly claims costs as Medicare beneficiaries move from an unmanaged Medicare system to an optimally managed care system.

The unmanaged system data represents an example of current utilization for a mid-west county. The optimally managed system represents the highest degree of healthcare management or the most cost efficient system. The degree of total healthcare management based on current standards is assumed to be 100% efficient for an optimally managed system. The moderately managed system represents a mid-point between the unmanaged and the optimally managed system.

The optimally managed system provides the most appropriate care at the most appropriate level of service. To achieve an optimal managed system, substantive changes must be made to the behavioral pattern of healthcare providers as it relates to access, utilization and reimbursement. These changes cannot occur without substantial management involvement from healthcare providers, otherwise unsatisfactory outcomes occur from the perspective of the insurer, providers, and the consumer. A Medicare Select program can assist in the transition process from an unmanaged care system to an optimally managed system.

Olympic Health Management Systems, Inc.

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Example of Changes in
Medicare Health Care Consumption

	Unmanaged System			Moderately Managed System			Optimally Managed System		
Type of Service	Annual Util Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost	Annual Util. Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost	Annual Util. Per 1000	Average Cost Per Services	Per Capita Monthly Claim Cost
INPATIENT HOSPITAL									
Non-Mat: Medical	1,543 8	937.72	120.64	1,071.0	1,139.31	101.69	598.2	1,659.41	82 73
Surgical	920 1	1,119.71	85 85	668 1	1,382.11	76.95	416.0	1,962.44	68 04
Psychiatric	36 6	450 66	1.37	25.7	477 19	1.02	14 7	542.93	0 67
Alcohol/Drug	15.1	331.23	0 42	9 6	376.96	0.30	4 0	535 88	0 18
SNF/ECF	933.6	156.60	12.18	747.9	156 60	9.76	562.2	156 60	7 34
Subtotal			220 46			189 71			158 96
OUTPATIENT HOSPITAL									
Emergency Hospital	321.5	186.32	4.99	220.2	198 89	3.65	118 8	232.91	2.31
Outpatient Surgery	63.4	1,304.51	6 89	58.7	1,334.51	6.53	54 0	1,369.74	6 16
Radiology	689 5	321.56	18 48	567 6	327 87	15.51	445 6	337 64	12.54
Pathology	741 4	105.37	6.51	610.3	107 44	5 46	479.2	110 63	4 42
Other	883 4	98.38	7 24	706 8	100.23	5 90	530.2	103.30	4 56
Subtotal			44.11			37 05			29 99
PHYSICIAN									
Inpatient Surgery									
Primary Surgeon	148 4	1,552.56	19 20	130.1	1,613 89	17 49	111.7	1,675 19	15 59
Assistant	29 9	713.75	1.78	28 4	720 59	1 71	26 9	727.45	1 63
Anesthesia	118 5	336.00	3 32	106 1	345 76	3 06	93.7	355 53	2.78
Outpatient Surgery									
O/P Facility	319.1	556.10	14.79	280 2	657.24	15.34	241.2	758.33	15.24
Office	720.2	111 48	6 69	642.3	115.25	6.18	564.3	119 05	5 60
Anesthesia	169.3	167.93	2.37	168 2	218 24	3.06	167.1	268 54	3 74
Hospital Visits	2,318 4	51.38	9.93	1,658 2	52.94	7.32	997.9	54 50	4 53
Extended Care Visits	122.8	57.13	0 58	108 6	59.17	0.54	94 3	61 20	0 48
Critical Care Visits	228 0	78.76	1.50	230.7	78 76	1.51	233 4	78 76	1.53
Office Visits	6,322.7	19.83	10 45	6,098 0	19 88	10.10	5,873.2	19 94	9 76
Home Visits	99 8	48.64	0 40	107.2	48 93	0.44	114 6	49.21	0.47
Therapeutic Injections	221.9	8.58	0.16	199 6	8 58	0 14	177.2	8 58	0.13
Allergy Testing	46 3	30 89	0.12	41 6	30 89	0 11	36 8	30 89	0 09
Allergy Immunetherapy	432.5	9 65	0.35	389.3	9.65	0.31	346 0	9 65	0.28
Diagnostic Testing	142 6	47 88	0.57	128 0	47 88	0.51	113.3	47 88	0.45
Emergency Room Visits	317.2	41 81	1.11	215 9	41 81	0.75	114 6	41.81	0 40
Consults	458 1	75.76	2.89	411 9	75.76	2.60	365.6	75 76	2.31
Physical Medicine	601.6	17.34	0 87	540.7	17.34	0.78	479.7	17 34	0 69
Cardiovascular	688 1	57.75	3.31	618.6	57 75	2.98	549.1	57 75	2.64
Dialysis	74.2	67 80	0 42	66 7	67 80	0.38	59.1	67.80	0.33
Chiropractor	503.4	23 89	1 00	452.4	23.88	0 90	401.3	23.89	0 80
Radiology	2,105 8	68.58	12.03	1,820.0	68 57	10 40	1,534 1	68 58	8 77
Pathology	8,689 9	23.65	17 13	7,353.5	23 65	14 50	6,017 1	23.65	11 86
Podiatrist	28.9	40.37	0 10	25.9	41 01	0 09	22.8	40.37	0.08
Outpatient Psychiatric	263 8	50.33	1.11	230.7	50.33	0.97	197.6	50 33	0 83
Outpatient Alcohol/Drug	121 8	46.91	0 48	106 5	47.32	0 42	91.2	46 91	0 36
Subtotal			112 66			102.59			91 37
OTHER									
Home Health	5,697.4	62.93	29 88	5,233 0	62 93	27.44	4,768 6	62.93	25 01
Ambulance	132.4	221 95	2 45	125.2	222.01	2.32	118 0	221 95	2.18
Durable Medical Equip.	991 6	38 10	3.15	901.3	38 11	2.86	810 9	38 10	2.57
Prosthetics	264 4	115.21	2.54	233 6	115.25	2.24	202.7	115.21	1 95
Subtotal			38 02			34 86			31 71
Total Claims/Benefit Cost			415.25			364 21			312 04

Problems Encountered with Medicare Select

The most significant problems associated with the implementation of Medicare Select include the following:

- **Fraud and Abuse**. Physicians generally are terrified of becoming involved in any Medicare managed care programs. Few attorneys are willing to provide positive counsel to physicians regarding their participation in a Medicare Select program because of the lack of Safe Harbors guidelines.

- **Lack of Insurer Participation.** There are relatively few insurers involved in Medicare Select programs. Most insurers have been skeptical due to the three year demonstration timelines and the potential negative impact on their policyholders in the event that Medicare Select was discontinued. Three years was never adequate considering the timeline associated with: insurance department regulatory adoption; the filing process; training and orientating personnel managing the programs; organizing providers; and implementing the marketing process. Indeed, a number of insurers would have been willing to promote a Medicare Select policy in the state of Massachusetts, but the Massachusetts Insurance Department has refused to act on Medicare Select until the issue of the demonstration status has been resolved.

- **Existing Managed Care Programs Were Eliminated.** The intent of Congress with Medicare Select was to encouraged managed care applications to otherwise standardized Medicare supplement insurance products. Ironically, the limitations of the pilot program actually SHUT DOWN operational PPO and HMO Medigap products in the other 35 states.

Medicare Select is Consistent With Insurance Reform.

Medicare Select policies are already governed by the type of reform measures Congress is seeking to impose on commercial insurance plans. As a subset of standard Medicare supplement regulations, Medicare Select includes regulations on: pre-existing conditions; portability; guaranteed renewal; open enrollment for individuals just turning 65; and agent compensation measures.

Medicare Select is a transitional product, representing an incremental step towards greater market reform. Medicare Select offers Medicare beneficiaries a friendly bridge into greater managed care programs such as the TEFRA risk contracts and encourages providers and insurers to work cooperatively within the market in preparation for future innovative reforms such as a Medicare voucher program.

Medicare Select offers a low cost alternative to older adults. Medicare Select premiums are up to 40% less than standard Medicare supplement policies.

Systems for consumer protection are already in place. Medicare Select policies must file a Plan of Operations for approval with the state Department of Insurance. The insurer must comply with quality assurance procedures, grievance and complaint resolution process, and ensure access to care. A Medicare Select policy CANNOT restrict payment in the event of an emergency, while the senior is traveling, or if services are not available in-network. Medicare Select is NOT an HMO or risk contract.

Improvements Needed With Medicare Select

- **Safe Harbors.** Medicare Select should be provided with the same safe harbors as supplied to Medicare Risk Contracts. Clearly, HCFA has the opportunity of auditing for compliance and it is this vehicle that should be employed relative to quality standards and utilization monitoring.

- **Office Visit Co-Pays.** As in the case of HMOs, Medicare Select should be allowed to offer a small co-pay per physician office visit. Small co-pays are an integral part of conditioning utilization behavioral patterns of Medicare beneficiaries.

- **Expansion to All States.** A clear message should be sent to providers and insurers that managed care is endorsed by the federal government by expanding Medicare Select to all fifty states on a permanent basis.

(admin/corres/splegal)

Chairman THOMAS. Thank you, Mr. Gauthier.

That is a point that I think we assume but it needs to be focused on, and that is people are trying to pick up signals from us and that if the signal was that this isn't even appropriate to move forward on, what else are we not going to do, I think that is very good.

On the open enrollment question, I don't know that it is necessarily a function of time. I am looking more at the need to provide education and knowledge so that decisions would be made.

My concern would be that if you had to just constantly go and have more salesmen making calls to move insurance, I would guess that that is probably where there is more of a chance for abuse. I would be looking to provide a more direct yet broader-based education and knowledge function for the seniors so they would make a choice, not so much to me the timeframe in which they make the choice, it is what they make it with.

Reaction?

Mr. GAUTHIER. Right now Medicare Select is not very well publicized, mostly because insurers are afraid to enter into the marketplace because of the demonstration status. So at this point, our only mechanism from our hospitals to promote this kind of a managed care program is to employ the traditional tools of direct mail group presentations, telecommunications, whatever is required to in essence get the message out. You can't simply do that in a 1-week period.

Chairman THOMAS. Ms. Musser, in terms of ability to communicate, what we have heard over and over again is that people just don't know about the program. Have you folks from your national perspective seen anything that looks good or any efforts that have been made that might be some models for us to see how it is that we can go about it? What have you done in Wisconsin?

Ms. MUSSER. The NAIC has a senior issues task force that works on senior counseling, bulletins, and brochures. The Wisconsin insurance department has a number of—I can think of at least four or five brochures that we send out on a regular basis.

We also have a little computer program that we have generated that the board on aging and some of the aging coalitions use. Senior citizens call us, they give us their age, gender, their riders that they want, and their location, and we generate premium comparisons and quotes for them on the telephone on a regular basis.

But you are right, the promotional, the marketing of it is restricted, and I think that is largely because it is not a permanent program. People are not investing in it the way that they might in product development if it were a permanent program.

I mentioned that Wisconsin had these programs prior to the enactment of the demonstration project. We have 40-some thousand people enrolled. The enrollments are going up and not down, but I think they would grow more rapidly if the programs were permanent.

Chairman THOMAS. Well, and if you are gearing up to provide only just a very narrow product, it takes a lot of effort, that is kind of an inverted pyramid to deliver the product on an educational basis. If you had more product available for the seniors, in terms of understanding the full panoply might be——

Ms. MUSSER. Exactly.

Chairman THOMAS. You rattled off some statistics during your testimony that apparently HCFA doesn't have. Are you in communication with HCFA and are we supplying some of this data?

It seems that it has evaded them, and I just think it is interesting that you folks are collecting data on a profile basis which HCFA either chooses not to focus on or isn't aware of. Have you had any communications with HCFA about the results?

Ms. MUSSER. I had a number of communications today about the statistics quoted in my testimony, and I think we will have ensuing conversations about them. Wisconsin collects——

Chairman THOMAS. Was it supportive or threatening? I am just curious.

Ms. MUSSER. Quite supporting.

Chairman THOMAS. Where did you get the stuff?

Ms. MUSSER. Wisconsin collects a lot of its information on this in profiles. The insurance department in the State of Wisconsin manages the HMO industry and has since its inception, including, you know, the filing of business plans and all of the financial data, and that is of course greatly helpful to us in collecting a lot of the information that we have because we know their enrollments by breakdown.

Chairman THOMAS. For the record, I believe it is the department of corporations in California that manages the HMOs and collects the information. That was a question earlier.

Ms. Shearer, in terms of your testimony, in looking at—and I have a copy of the August 1994 Consumer Reports with your value index from poor to fair to good to very good to excellent, and you have a number of products, in fact the third, the fourth, the fifth, the seventh, the ninth best-rated value products are Selects—and in looking, for example, at the second most highly and the third most highly rated Select products, the method of rating is attained age. You had some relatively critical comments to make about that kind of a profile.

Was that not used in terms of classifying it on the value index or is there a warning label placed on the product, or how did you go about taking the testimony that you gave us and giving somebody a comfort level that the highest rated, the fourth highest rated insurance program was in fact the one that had this very poor way of rating.

Ms. SHEARER. This table is, the ratings are based purely on premiums over different age groups for consumers. If you look on page 526 of the article, a column marked "Pricing Pitfalls," that is where this issue of what we consider to be the hazardous pricing structure is addressed. But the table, the ratings——

Chairman THOMAS. I have to confess, the way I read your magazine most often is that I tend to just skip over the written material and go to the little rating structures so that I don't have to waste time plowing through what you guys plowed through, and I take your judgment based upon all of that stuff because it is an index, it is a value index, it combines all of that stuff. But you are telling me that it didn't here?

Ms. SHEARER. I am telling you what we tell our readers: Read the whole article because it is really important, and this applies to issues beyond this. And I am sorry, one of the challenges Consumer Reports has had over the years is how to make information accessible to consumers, and there is a tradeoff. I mean, you can put so much in a table.

Chairman THOMAS. Well, OK. Then I should have read it and be wary of the attained age Select packages.

Actually the highest rated Select is one with community rating, which is the third highest of all of them that you rated.

Ms. SHEARER. And what we are suggesting is, let's make all of them community rated. We are not suggesting that the Medicare Select market should compete with an unlevel playingfield against attained age or issue age rated policies, so we are suggesting that if a State wants to offer Medicare Select that they should community rate this market.

Chairman THOMAS. But even if they do that, you don't think it is a very good product?

Ms. SHEARER. I think that the jury is still out. There are many unanswered questions.

Our reading of the RTI study is that the main reason that there are cost savings at this stage is because of discounts that this product gets, but I realize that there is some research underway, there is some data from Wisconsin that I have not had access to.

I think the experience—one thing the RTI report showed very clearly is that the experience varies from State to State, and I think it is very important for Congress to have the best information before locking in a program. And I think once this program is made permanent, it is going to be very hard to change when new ideas for Medicare PPOs emerge or whatever.

Chairman THOMAS. I will tell you, not with this Congress it won't. That has been one of the problems in the past. We are into kind of a chicken-and-an-egg problem. You don't want us to go forward until we really have a picture what the world looks like, and we have had testimony all day that HCFA is almost incapable of providing useful comparative tools in a timeframe that means anything anymore, and that therefore your position is, don't go forward, versus the other position which is, well, go forward in this limited area, and we are going to continue to build tools as we see it.

So in terms of the chicken and the egg, given the timetable that we have pressure under, to me the compelling evidence is very simple: You go forward. You don't just stop and hope HCFA in the next 3 to 5 years comes up with some measuring device that will tell you that the program that they only wanted to continue for 6 more months might have had a chance to survive.

That is my problem in listening to the kinds of warnings that you are putting forward to us in not going forward in this very small modest area.

Ms. SHEARER. I would urge you to fix what is broken in the market before going forward. I tried to outline in my testimony some of the things that we think are broken. We have not recommended that you kill this program. We urge you to proceed with caution and not lock in something that isn't serving consumers well.

Chairman THOMAS. I understand. We are under tremendous pressure because we failed in the 103d Congress to do some of those fundamental reforms in the insurance area, in the malpractice area, administrative simplification, and creating some understanding within the Justice Department Antitrust Division that people do operate on timelines other than bureaucracies and that those timelines for decisions should be shrunk to a reasonable time with safe harbors created.

Ms. MUSSER. May I just comment a bit on that.

What you see when you look at some of the success stories, and one of the things that I would certainly agree with my predecessor about is that the State variation is pretty significant and we have to look very carefully at that and we should learn some lessons from it.

Where it is working well are in mature managed care markets. Managed care is not managed care is not managed care across the Nation.

Some points that you made earlier, Mr. Chairman, about introducing managed care concepts are critical in the immature markets. As we get people from managed care in the workplace into these markets, these programs will continue to refine themselves as they did in Wisconsin, Minnesota, California, and many other States. We didn't all of a sudden just jump in and be successful with this this last year. This takes time, and it takes time to develop the products, to refine the products, to listen to the customer choice.

I think the issues of attained age are issues of product selection and disclosure and information, and I think those are the kinds of lessons we learn in States like Wisconsin where we have a more mature market.

Chairman THOMAS. The pressure I am under, Ms. Shearer, is that all the statistics that are coming in now, despite the fact that people say, "Well, we don't know if the trend is going to last a very long period of time. Given the kind of fundamental shifts that have occurred in the private sector, you are not going to reverse them. They are going to continue." So for folks to say, "Gee, we ought to wait or maybe it is a blip," I don't have much patience with those kind of folk.

What I got out of part of your testimony was that you have to be careful because there is going to be a cost shift in terms of the cost shifted over the hospitals. What the statistics are screaming back at me is that it is Medicare that is beginning to be the cost shifter into the private sector and that the folks out there have learned their lesson, they aren't going to take the shifts anymore.

And so it is exactly the opposite, and that government might be performing a kind of a useful function here if in those areas where the managed care market and the knowledge among consumers is not as great, we could be doing a great service for folks in this particular area to begin to develop the kinds of tools and the assurance. If we do it right, government believes that this is an appropriate way to go that can speed up the markets.

I was just amazed at when you look at where managed care has been successful, it is kind of like following where import cars are sold highest and American cars are not. It is the Midwest and other areas that aren't up to speed, but it is not just in this program, it is across the board in terms of managed care. So if we were to go to 50 States, make it permanent, come up with some tools that will allow folk to make those judgments, one, we get better at what we are doing; and, two, it creates an understanding and acceptance for the private sector to continue to move forward more rapidly in areas where it wasn't.

Now why is that bad?

Ms. SHEARER. I think the cost shifting issue is certainly bigger than Medicare Select.

Chairman THOMAS. Of course. It is all Medicare now and as such, it has become an anchor, a drag on the system.

Ms. SHEARER. My concern is that with discussion of expanding the discount to Medicare Select to part B, for example, if discounts are where the cost savings are coming from, whether it be part A or part B in the future, then I don't think it is fair to hold this up as a cost saving program. I think this is the type of thing that needs more study and analysis before locking it in.

Chairman THOMAS. Who held it up as a cost saving program? See, if I can get better quality of care for the same price, that is a plus. And if I save money along the way or if the consumer saves money along the way, isn't that a plus, too?

If you have a program that—if you have a product in your magazine that really delivers on what it says and it is cheaper, don't they get a "check" in terms of a best buy, that those were "pluses," those were positives when those two things came together.

Ms. SHEARER. Well, right now the premiums appear to be lower in large part because they are not paying all the costs, so I think this is a very——

Chairman THOMAS. Based on what, 3-year-old data, 5-year-old data?

Ms. SHEARER. Based on the only objective analysis that has been available to me, which is a 1-year-old study, and what I feel is—it is the RTI study, and that is all that I have had access to.

Mrs. JOHNSON. That study is only now out as a single example, and they haven't gotten to cost yet. They haven't. That study has not reported on cost.

Mr. CHRISTENSEN. We heard witness testimony earlier that the study wasn't correct anyway.

Chairman THOMAS. You can have a judgmental about whether it is worth anything or not, but it just amazes me that someone looks in the last 12 months what has occurred in the private sector in terms of costs in significant reductions in that area and that those folks who have changed the marketplace are going to continue to be able to, you know, absorb cost shifting, to me is just a total disconnect of what is really going on out there.

So obviously another 12 months will give us a better picture. Hey, another 5 years will give us a whole lot better picture, and then, guess what? We have 1 year to solve the bankruptcy of the health insurance market.

All we are trying to do is push the envelope a little bit in an area that seems to be, at least in those States that are more mature markets for managed care, who understand what they are dealing with and have gone one step beyond nothing in terms of trying to inform the seniors, that it looks like it is kind of useful.

So, again, it is a “flying knot” versus the alternative. I guess that is the problem.

Ms. SHEARER. Mr. Chairman, I would really urge you to look not only at the States where Medicare Select appears to be very successful, but to study carefully the States where it hasn't taken off, where the States have dropped out of the program, where it has not worked as well as it has in Wisconsin.

Chairman THOMAS. I assure you we are going to, but it is not to try to find out why we stop other States who are successful, it is to find out how those States that have successful programs can be transplanted into those States that have not.

We are just coming from a completely different direction on how you solve the problem. My goal is to move forward, not to find reasons for not moving forward. I guess that is the difference.

Mr. GAUTHIER. If I could just make one comment from the provider side. Of the 180 contracts we have negotiated with 6 different insurers, the vast majority of them have a component in those contracts that basically say that if the plan performs properly, the hospitals will share in the positive plan performance. So even with a Select product there are some incentives for providers to work together in order to make this product successful in the marketplace.

Most of our hospitals firmly believe that over time 50 percent of their population will be in some form of a Medicare risk product, and that timeline is probably 5 to 10 years. They are concerned with getting involved with Medicare Select to get the experience in terms of managing the process of case management, managed care, negotiations, working with their physicians, capturing the data, and positioning themselves for what they believe to be a continuous reduction of funding for hospital services.

This issue goes beyond just writing off deductibles and coinsurance. It has everything to do with hospitals and the system's preparing itself for a much larger issue.

Hospitals are terrified that funds won't be there beyond the year 2000 to take care of Mr. McDermott's 85-year-old person. That is not the issue. The hospitals are generally concerned with that.

The deductible is irrelevant. Most of our hospitals enter into this program not to increase census, not to write off the deductible, but because they need the data. They need the data because the Federal Government simply does not provide that information to them.

Hospitals have no idea what physicians are doing, physicians have no idea what hospitals are doing, and the whole issue of getting them to work together under a low-risk product, is a darned healthy thing to do in a free marketplace.

Mrs. JOHNSON [presiding]. Thank you very much.

Let me just—the hour is late—go to Mr. Christensen, and then I have a couple questions and we will adjourn.

Mr. CHRISTENSEN. Thanks, Madam Chairwoman.

The point you just made, Mr. Gauthier, to what degree do you think it is the hospital's concern of getting into a program that is going to be eliminated because it is a demonstration project? To a great degree?

Mr. GAUTHIER. I think most hospitals, or at least we advocate that over time, and we measure this because a lot of the managed care markets we are in, think that over time you will probably see

50 to 60 percent of the population on a voucher system or a Medicare risk product, perhaps 20 percent will be in a Select product, and the rest of it will still be in some form of ERISA or indemnity product. That is our best guess from what we know today.

If the system doesn't evolve in that process, you can't possibly afford to fund Medicare with the baby boom population coming online. I think hospitals recognize this, so they look at Select as a steppingstone for them to learn the process of negotiating with physicians and all the other components with managed care to get into a risk product.

Mr. CHRISTENSEN. In your testimony on the last page you talk about offices that charge copays, and you say small copays are an integral part of the conditioning utilization behavioral patterns of Medicare beneficiaries. What would be your example of a small copay?

Mr. GAUTHIER. $5 to $10 copay. The current rules are you either pay the deductibles or you don't. It is as simple as that.

So when we structure a plan with our physicians and with the hospital, when the senior goes to a physician's office, we either pay the deductibles or we don't. There is nothing in between.

We think putting a product out there such as an HMO so that there is a $5 or $10 reminder when that senior uses the physician's office, would do a lot in terms of reducing the premium as well as encouraging that senior that nothing is for free. Right now we simply can't do that with any of the Select products.

Mr. CHRISTENSEN. From the standpoint of Wisconsin and moving away from the Medicare Select issue for just a moment to the general Medicare issue, consumption and overconsumption is something that this committee has looked at for some time now. What do you see in Wisconsin that would work as a copay type of arrangement?

Ms. MUSSER. Wisconsin has been approached very recently by an HMO who wants to begin entering into the Medicare risk contract area and has asked for our interpretation and approval of a small copay. I don't know the exact level of that, but we are moving forward to approve it.

I believe it is in the area, the range of the $10 per visit or 20 percent kind of arrangement to assist them with some kinds of office visits and some kinds of medications and situations. We are moving forward cautiously on a limited basis, but we think that the flexibility is needed to restrain the utilization.

Mr. CHRISTENSEN. That is all I have at this time, Madam Chairman.

Mrs. JOHNSON. Thank you, Mr. Christensen.

Ms. Shearer, in your comments you quote the RTI study, but you don't mention the part of that study that found that the 3-year 15-State limitation was a significant barrier to the expansion of Medicare Select.

In the RTI report it says, "Unless a firm is already offering a similar product, 3 years is not enough time to develop a product in a provider network, market it, and recover the initial investment."

In looking at this issue, why didn't you consider that part of the study as well as those parts that you included in your testimony?

Because the implication in your testimony is that it didn't spread because it wasn't any good.

Ms. SHEARER. Well, it certainly is one factor, and in limited time and limited space I didn't mention it, focusing on some of the concerns that the RTI pointed out in terms of what is most important to consumers. And I think that that is the kind of point that industry is better positioned to make, but——

Mrs. JOHNSON. Thank you.

I would just remind you that in other testimony this morning we have heard that the RTI study was done when the program was in its infancy, and the RTI study itself cautioned that the results are in many ways preliminary and the most extensive section is a single-State study and they have yet to offer the cost section of the study and the other section on beneficiary satisfaction. So we have those yet ahead of us.

I do want to ask though the time is late, but I am very interested in the issue of the States where it hasn't taken off. I think there are probably some obvious reasons why not, but, Ms. Musser, if you could help us with that and gather any information that you can about those States where it hasn't been as active. And then I am also interested in the issue of attained age because we do have consumer protection provisions in our Medigap policy law, but also we regulate these kinds of policies at both the Federal and State level, and one of the regulations specifically goes to trying to be clear with seniors about what they are and are not buying, and if we are not telling them that there is a difference between buying this and another Medigap product, then we ought to be doing so.

Now, this is not a Medicare Select unique issue. This is a Medigap policy across the board. But I think that is a reasonable thing to deal with.

Personally, in some of the testimony you have implied that seniors might be duped. That has not been my experience. My experience is that most of my seniors know more about tax law than any 40 year old I represent as a group, and that they are very sharp, and they sit with each other and they compare benefits and dollars, and they know exactly what they are getting. Would that most of us were as sharp consumers as they were in their earlier years, though that is no longer true of my 95-year-old mother.

So I think we have an opportunity here as we move forward to make sure that any knowledge we have that could improve the opportunity for this program to serve seniors well in the States where it isn't currently built into the program. To deny the overwhelming testimony, however, of how many more benefits seniors are getting through this plan and what the satisfaction level is in the better plans and the contribution it is making in the States that it really had the ability to work with is because they have the provider sector development necessary. Isn't information we can afford to look at and say, well, we will do a 6-month extension. It is too pathetic a legislative response.

So we look forward to working with you. You know now what we are going to do. You know what information could be useful to us in doing it well.

We thank you for your testimony and invite your continued involvement.

[No information was received at the time of printing.]

Mrs. JOHNSON. Thank you.

[Whereupon, at 3:44 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

BY

CHIEF MASTER SERGEANT JAMES E. LOKOVIC, USAF (RET.)

DIRECTOR, MILITARY AND GOVERNMENT RELATIONS

AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished members of the committee, I am here on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents all enlisted Air Force, Air National Guard and Air Force Reserve members, their families, and survivors. Many of our members have served their nation, have entered their retired years, and are now among those currently being served by the Medicare system. Accordingly, we appreciate this opportunity to include AFSA's views in your important deliberations.

We are well aware of the important challenge to be faced by this committee, greatly appreciate your focus on controlling costs and improving care, and are sensitive to the enormous growth in Medicare expenditures in recent years. The overall costs and fees for service become especially significant for our members because enlisted military retirees are among the lowest-paid annuitants. As you are looking at ways to control costs and improve care in the system, we would like to suggest two important money-saving possibilities.

Our first suggestion is that the committee support **Medicare subvention**: the transfer of funds from the Department of Health and Human Services (HHS) to reimburse the Department of Defense (DOD) for care received by Medicare-eligibles at Military Treatment Facilities (MTF). Representative Joel Hefley's H.R. 580, introduced during this Congress, would allow this interagency transfer of funds. His bill realizes that the question is not spending HHS dollars versus DOD dollars; the real possibility is to save *taxpayer* dollars by the non-parochial transfer of funds.

The advantage in cost-savings would be that HHS would spend fewer dollars for the care it buys at MTFs than it does from civilian providers. Savings are derived through "utilization management," which is preventive in nature. This DOD-unique system gets the right treatment in the right place at the right time. This heads off more serious treatment problems and thereby holds down costs. Also, the cost of physicians is significantly tempered by the military rank structure. Finally, MTFs already have an infrastructure in place, so the basic care components are there. The results, when comparing MTFs to civilian providers, are savings in costs, overhead and mark-up fees.

Whereas all military retirees are eligible to seek space-available care at MTFs, most are viewed differently after they are forced to transition from CHAMPUS (soon to be TRICARE) to Medicare. In practice, MTF commanders are facing smaller and smaller budgets, and our older members tell us that space-available care has been increasingly denied for Medicare-eligibles because of lack of treatment funds. Thus, AFSA feels that the practice of Medicare subvention would make on-base care more likely for our older retirees and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees.

We would also suggest that as this committee looks at ways to incorporate managed care ideas into the Medicare system, great consideration should be given to **allow Medicare-eligible military retirees the option to remain in the military health services system through the TRICARE program.** This three-part system, DOD's health care plan of the future, is currently available only to under-65 military retirees and their dependents, and active duty family members. TRICARE includes an HMO option, TRICARE Prime. TRICARE Prime's enrollment fee and cost-shares also provide lower-cost care than traditional "fee-for-service" care associated with Medicare Part B insurance.

The lower pension income of enlisted military retirees and their survivors magnifies the issue of health care costs. The TRICARE program promises to offer enrollees much lower costs than current fee-for-service insurance programs. Also, while the committee is looking at areas of private managed-care plans it can incorporate into the Medicare system, we would argue that serious consideration should be given to extend HHS reimbursement to DOD for enrollment in the TRICARE program for military retirees over 65. Again, military retirees would be allowed to stay in the military health services system for life and, at the same time, reduce the cost of care for Medicare-eligibles.

Mr. Chairman, again, thank you for this opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are investigating the numerous facets of the problem, we would suggest that you give serious consideration to AFSA's ideas on the matter. While these primarily apply to military retirees and their families who are Medicare-eligible, the savings to be realized may well be considerable if you consider incorporating use of the military health services system. Approving ways to keep all retirees in the military health system is not only cost-effective, it also keeps a promise made to retirees, i.e., that they would have lifetime, affordable care as part of the military family.

The men and women of the Air Force Sergeants Association wish you well as you work to accomplish your important mission. As always, we are available to assist you in matters of mutual concern.

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of the American Academy of Family Physicians, an organization representing 80,000 practicing physicians, residents, and medical students, please accept this statement for the record of the February 10, 1995, hearing on Medicare reform and innovation.

The Academy recognizes that Medicare will be targeted for substantial expenditure reductions and policy changes designed to achieve a large portion of the approximately $1.4 trillion in savings needed to achieve a balanced budget by the year 2002. This will be a difficult task involving by some estimates at least $40 billion in Medicare spending reductions annually for the next seven years. As you and your Ways and Means colleagues search for these savings, we urge you to take advantage of the **proven** savings that can be achieved by correcting anti-primary care biases and alleviating regulatory burdens in the current program. Implementing changes such as those described below will generate meaningful savings, bringing the economy nearer to a balanced federal budget, while also improving the quality of care for Medicare beneficiaries.

Congress will consider a wide range of proposals designed to reduce the rate of increase in Medicare expenditures, including higher beneficiary cost sharing, enrolling a higher proportion of Medicare beneficiaries in managed care plans, Medicare vouchers, and medical savings accounts. While each of these reform proposals holds some theoretical possibility of reducing expenditures, there is only one factor that has been consistently proven to hold down per capita Medicare expenditures, **the availability of primary care**. Your success in controlling Medicare outlays will be directly related to your success in improving beneficiary access to primary care services.

Primary Care and Medicare

Primary care physicians--defined by the Council on Graduate Medical Education as family physicians and general practitioners, general pediatricians, and general internists--deliver health care services more efficiently and in a less costly manner than subspecialists. Family doctors, for example, treat 85-90 percent of the presenting conditions of an undifferentiated patient population and take responsibility for managing the care of those patients who are referred for subspecialty services.

There is extensive literature supporting the conclusion that primary care is cost-effective, and several of these studies are specific to the Medicare population. For example:

- There is an inverse relationship between the extent to which a nation's primary care system is developed and the per capita cost of health care. (Starfield; JAMA, Oct. 23/30, 1991)

- Per capita health expenditures decrease as the proportion of family and general physicians increases. A systematic evaluation of variation in Medicare expenditures for physician services across the U.S. concluded that a higher proportion of primary care physicians in a metropolitan statistical area is associated with a significantly less expensive practice of medicine overall, for both in-hospital and out-of-hospital care. (Welch et al; NEJM, March 4, 1993)

- A study of per beneficiary Medicare expenditures for physicians services found that the most important factor explaining lower expenditures in rural areas is the mix of physician specialties. Expenditures are significantly lower when the proportion of general and family physicians is higher and expenditures are significantly higher when the proportion of subspecialists is higher. (Dor and Holahan; Inquiry, Winter 1990).

- Increased availability of primary care services for low-income populations reduces the inappropriate and expensive use of emergency departments. In one study, nearly half (45 percent) of patients waiting for emergency department care cited unavailability of primary care services as their reason for using the emergency department. Only 13 percent of those waiting had conditions clinically appropriate for the emergency department; 38 percent were willing to trade the emergency department visit for assurances of an appointment at a primary care clinic within 3 days. (Grumbach, et al; AJPH, March, 1993)

- Given an equivalent patient population, primary care physicians provide more cost-effective care than their subspecialty colleagues. The recent Medical Outcomes Study reported that cardiologists, for example, hospitalize patients with similar levels of illness at more than twice the rate that family physicians do, and ordered more tests, etc. After adjusting for patient mix, cardiologists and endocrinologists had utilization rates that were considerably higher than those of generalists for all health care resources. (Greenfield, et al; JAMA, March 25, 1992)

These studies point to a stark reality of American medicine: it is overly specialized and overly costly and the two are directly related. No matter what other reforms Congress may consider and adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

The studies cited above point to the fact that when primary care physicians in general, and family doctors in particular, are used by Medicare enrollees, the program reaps savings. However, despite these positive and encouraging findings, the Physician Payment Review Commission (PPRC) and the AAFP itself have discovered disturbing access problems centered around primary care services for Medicare beneficiaries.

In its 1994 annual report, the PPRC summarizes the results of a 1992 physician survey showing that 10 percent of primary care doctors were not accepting new Medicare patients. The AAFP found that by region 17-35 percent of its practicing members are not accepting new Medicare patients. Over one-quarter of family physicians' patients are Medicare beneficiaries; this figure is even higher in rural areas. Despite steps Congress has taken, most recently in the Omnibus Budget Reconciliation Act of 1993, to protect primary care services from fee reductions, anti-primary care biases in the fee schedule remain a sizeable problem. Just as importantly, given the disproportionately low number of family physicians in the workforce today, it should be noted that most family practices are full--another pressing reason that our membership cannot accept new Medicare patients.

Given the potential for widespread Medicare savings when primary care and family physician services are maximized, we strongly recommend that steps be taken to completely eliminate anti-primary care biases in the Medicare program. At a minimum, this shift would involve specific changes in the fee schedule and a redistribution of Medicare's graduate medical education (GME) funds to boost the number of family physicians trained.

The Fee Schedule

Given the desirable cost-saving benefits connected with the use of primary care physicians by Medicare enrollees, removing anti-primary care features from the physician fee schedule is an important part of Medicare reform. Therefore, the Academy believes the following improvements with respect to primary care payments under the Medicare fee schedule are needed to improve beneficiary access to primary care services.

First, Medicare payment for visit services, which are the type of service that primary care physicians most commonly provide, are generally inadequate. Indeed, Medicare payments are only slightly more than half of private sector payments and often are below the cost to the physician of providing the service. Inadequate payment rates are the most important reason so many family physicians no longer accept new Medicare patients.

In general, we believe the work involved in visit services is greater than the values assigned to them by the Medicare fee schedule. The intensity of these services is uniformly and inappropriately lower than the intensity values assigned to other services, such that even highly complex visits on extremely ill patients are valued lower than very minor, straightforward skin procedures.

Since the work relative values for visit services were implemented in 1992, medical practice has changed substantially enough to create a compelling rationale for believing that the work involved in visit services is currently undervalued. Specifically, patient complexity has changed as patients enter the hospital later and leave sooner. The patient population is aging. New drug treatments and more sophisticated diagnostic tests have increased the complexity of factors physicians must consider in their medical decision making. More sophisticated diagnostic tests have produced more results for physicians to explain and discuss with more people, many of whom are better informed and, therefore, more inquisitive. Considered together, these changes in medical practice have increased the mental effort, judgment, and physician stress associated with providing a service, while adding to the amount of work that a physician must perform after the face-to-face visit is concluded. This postservice work is included in the basic visit fee. Accordingly, we have requested as part of the statutorily mandated five-year review of the Medicare fee schedule a re-examination of those E/M services for which we have a compelling rationale they are undervalued. These E/M codes are: 99213, 99214, and 99215 (established patient office visits); 99231, 99232, and 99233 (subsequent hospital visits); and 99238 (hospital discharge day service).

Second, there is a well-documented anti-rural bias in the Geographic Practice Cost Index. The GPCI is intended to measure geographic differences in physician practice costs. Instead, the Academy believes there should be a single fee for the same service--regardless of where it is located.

It should be noted that the GPCI index does not actually measure physician practice costs, but, rather, is based on "proxy" data. For example, instead of measuring physician office costs, it uses a national index of residential apartment rents. The flaw in Medicare's GPCI is illustrated dramatically in its conclusion about the relative difference in urban and rural practice costs. The GPCI purports to show that rural physician practices are significantly less expensive than urban practices. In fact, multiple studies conducted over many years show conclusively that rural practices are every bit as expensive as urban practices. The GPCI systematically and unjustifiably penalizes rural physicians. The differential between urban and rural payments for the same service can be as high as thirty percent.

More than any other specialty, family physicians locate in rural communities. To reiterate the AAFP's position, we believe there should be no differential in physician fees based on practice location. Instead, there should be a single fee for the same service regardless of where it is located. We base our position on the premise that equivalent service should result in equivalent compensation. Furthermore, our position is consistent with federal policies that incorporate uniform national rates. For example, uniform national rates apply to federal income tax, social security payments, and the Medicare Part B premium. A policy of uniform payment should only be modified, in our view, to achieve explicit policy goals (e.g., targeted adjustments for demonstrated shortfalls in access to care).

Third, we continue to believe that visit services are undervalued due to the practice expense component of the Medicare physician fee schedule. Basing practice expense relative values on historical charges, as the current fee schedule does, rather than resources, unfairly impacts the value of office visit services. We recognize that the basis for these relative value units is set in law, and we are encouraged that Congress mandated resource-based practice expense relative value units as part of the Medicare technical amendments signed into law last year. We look forward to working with the Health Care Financing Administration to implement this change.

A fourth flaw in the fee schedule relates to how visit services are undervalued due to the current Medicare Volume Performance Standard and conversion factor system. Since the inception of the MVPS, surgical services have repeatedly received a higher update resulting in an ever-increasing disparity between the fees for surgical services and those for primary care services. This cumulative differential has the perverse effect of undermining the redistributive effect intended under physician payment reform. The PPRC and others have commented extensively on this problem.

We are studying the current MVPS and conversion factor system for improvements and would pleased to work with you and your committee colleagues on this matter. In particular, we believe attention should be directed at the current use of multiple MVPSs and conversion factors and the question of whether a single MVPS and conversion factor would be more appropriate. Multiple MVPSs and conversion factors disturb the relationship between surgical and primary care services by valuing the work of the former at a higher level than the latter. In this regard, we note that the PPRC has concluded "that a single target and update would best maintain the integrity of the resource-based relative value scale." (PPRC Annual Report 1994)

The Workforce Quandary

The evidence linking excess costs to the growing supply and the extreme over-specialization of the U.S. physician workforce has been corroborated in a number of recent studies. Both the specialty imbalance and aggregate surplus are steadily worsening. It is eminently clear that if Medicare is to provide access to appropriate medical care with reasonable cost constraints, the aggregate supply must be limited and the proportion of generalists must be substantially increased.

The aggregate supply and specialty mix of physicians currently produced in the U.S. medical education system are a direct reflection of the financial incentives in the federal programs supporting these activities. Specifically, the strong inpatient bias in Medicare's graduate medical education support and Medicare's traditional under-payment for primary care services have powerfully influenced the distribution of the physician workforce towards specialization. Ironically, while the market for medical care increasingly demands more primary care services, the medical education system continues to produce a surplus of physicians narrowly trained in subspecialty fields. Changing the specialty mix of the physician workforce will require a reversal in the current incentives and establishing a meaningful connection between the market for medical care and medical education.

A July, 1994, report by the Office of Inspector General of the Department of Health and Human Services reached the same conclusion as the AAFP. In that report, the Inspector General recommended that the "Health Care Financing Administration (HCFA) reevaluate Medicare's current policy of paying GME costs for all physician specialties. In its reevaluation, HCFA should consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME costs for specialties with a surplus of physicians." We concur and urge you and your Ways and Means colleagues to include such language in the Medicare reform legislation produced by this committee.

In order to make primary care services available to Medicare beneficiaries, Medicare GME funding must support primary care training. Primary care training is based in ambulatory care. The AAFP believes any serious Medicare reform proposal should, at a minimum, include the following GME changes:

- an elimination of the penalty that teaching hospitals incur for the time that residents spend training in non-hospital owned ambulatory facilities;

- an extension of eligibility for direct GME payments to non-hospital entities that operate approved residency programs; and

- an up-weighting in direct and indirect GME payments for residents in the primary care specialties.

In addition, the AAFP has very strong concerns about the future viability of family medicine residency programs if Medicare Indirect Medical Education (IME) funds are reduced by 3 percent--as proposed by some lawmakers. Current medical education policies favor non-generalist training programs at the expense of family medicine, making them more lucrative than family medicine. If IME reductions are enacted, we have strong reasons to fear the family medicine programs will be targeted for severe cutbacks or even elimination in some hospitals. Further hindering efforts to produce family physicians in this fashion is insupportable.

Simply stated, the savings realized by Medicare beneficiaries treated by family physicians and other primary care providers cannot be achieved without substantially more generalist physicians in the workforce. These and other recommendations would bring Medicare's training incentives into alignment with market forces to ultimately create savings for the program.

Underserved Bonus Payments

By whatever measure you might employ, this nation suffers from a severe shortage of primary care physicians, and some geographic areas are particularly underserved. Since 1986, the number of federally designated primary care health professions shortage areas has increased from 1949 to 2492, and the number of primary care physicians needed to eliminate these shortages has grown from 4314 to 4677.

Since 1989, physicians who treat Medicare patients in HPSAs have been entitled to bonus payments equal to 10 percent of the amount Medicare pays for services. In theory, the bonus payments act as incentives to attract new physicians to underserved areas and to discourage physicians in those areas from leaving. However, as recent reports by the Physician Payment Review Commission, the Council on Graduate Medical Education, and the HHS Inspector General's Office confirm, the Medicare bonus payment program is not well structured for this purpose.

Almost half of the money distributed by Medicare in the form of bonus payments accrues to physicians who provide little or no primary care. In addition, almost 15 percent of bonus payments go to urban, hospital-based subspecialists.

Congress should modify the Medicare incentive payment program to target it more effectively to primary care. We support the Inspector General's recommendation that the program be changed to provide 20 percent bonuses to physicians providing services in HPSAs and eliminate bonuses for specialty services in urban areas.

Inflexible and Clinically Inappropriate Medicare Rules

Removing anti-primary care biases from the Medicare fee schedule will make a significant contribution toward the savings needed to achieve a balanced budget. Lifting rigid and clinically unsound regulations could take us even closer. Medical regulations have a disproportionately large impact on primary care practices and serve as a strong disincentive for medical students to select primary care careers.

As you know, Medicare is one of the most complicated and confusing programs administered by the federal government. Each year, physicians are faced with increased layers of requirements and inconsistent instructions. Not only are these regulations cumbersome and expensive, they are often badly conceived from the perspective of patient care. Exceptions from Medicare's rigid rules, even for reasons of medical necessity, are hard won, and must in every case be justified with exhaustive, often redundant, documentation. The cumulative expense and frustration is such that many physicians are reluctant to accept new Medicare patients into their practices.

The PPRC noted in its 1994 Report to Congress that increased paperwork was the second most frequent complaint registered by physicians with respect to the Medicare program. Similarly, a 1993 study of family physicians' satisfaction with their practices concluded that "The number of physicians considering external regulations and paperwork as problematic has increased from a bare majority [in 1983] to almost unanimity [in 1993]." According to this study, regulations by government agencies and the amount of paperwork involved in medical practice are now felt to be moderate to large problems by 90 percent of practicing family physicians. It is telling that a survey done by the Academy found that family physicians spend an average of 20 percent of working hours attending meetings or doing administrative tasks often the direct result of federal regulations. This is simply misdirected and wrong--physicians are trained to serve people, not push paper.

CLIA - The Clinical Laboratory Improvement Amendments (CLIA) is a particularly onerous and misguided law. CLIA was created in response to highly-publicized problems with cytology testing in commercial labs, and now regulates the full scope of medical testing, including testing done in physician office labs (POLs). The net effect of this statute and its implementing regulations has been decreased access to care for Medicare beneficiaries and an increased cost of tests. The AAFP urges Congress to exempt physician office labs from CLIA.

The requirements imposed on any physician office that maintains a laboratory for the benefit and convenience of patients are extraordinary. Under CLIA, physician office labs which perform only simply tests are waived from the law's proficiency testing requirements. However, "waived" labs are required to pay a $100 fee each year to register their waived status with the federal government. Physicians have never understood why a waived lab doing waived tests and therefore exempted from lab testing requirements must register with HCFA.

CLIA certification and documentation requirements for non-waived physician office laboratories are even more formidable. For example, as a matter of sound medical practice, physicians always record patient tests and results in the medical record. However, CLIA requires physicians to maintain a separate office record in which all laboratory tests and associated information are to be logged in chronological order. Such a requirement may be necessary in a centralized lab that has no other record of the patient, but for the physician's office, it simply represents extra, duplicative paperwork with no practical or clinical utility.

In a 1992 fiscal impact study of CLIA, Levine Associates estimated the administrative costs of recording data, maintaining files, producing manuals, hiring additional personnel to handle additional administrative tasks, time of existing personnel, and so forth and so on, to approach 25 percent of the total costs of CLIA implementation. These kinds of requirements render physician office lab financially non-viable, resulting in closure of such labs.

As a direct result of CLIA regulations, a 1993 family practice survey found that a large number of family physicians no longer provide the level of in-office testing they believe is necessary to serve their patient populations. The number one reason cited was "too much government red tape." Instead, many physicians now send their Medicare patients across town (or out of small rural towns) to large hospital or commercial labs for any testing, at a substantial increase in cost and inconvenience to the beneficiary.

Physicians are particularly bitter about CLIA. The reason is that there is not a shred of evidence that CLIA improves the quality or safety of laboratory services in physician offices.

Laboratory service payments - Medical necessity documentation for laboratory services is another area where Medicare could realize substantial savings by lifting much of the regulatory burden. HCFA is currently considering a new requirement for physicians to supply documentation of medical necessity when ordering more than 12 automated lab tests. As the AAFP stated in its comments on this proposed requirement, it is a misguided approach to a recent fraud case of labs billing for more tests than the physicians ordered. As you may know, HCFA claims Medicare could save $60 million by implementing medical necessity documentation requirements for laboratory services. However, we believe that the administrative costs associated with the change are likely to far exceed the costs of any unnecessary testing. It is clear to us that HCFA's proposed "solution" is to penalize physicians rather than the few labs who were the real culprits.

Automated lab tests are frequently conducted in panels or packages in which several tests are performed concurrently. It is cheaper and more efficient to order a multi-panel test than to order individual tests a la carte.

Some time ago, several reference labs were accused of billing for tests that were not ordered. There were instances when a physician ordered a panel of tests, and the lab unbundled the services, submitting the charges to HCFA as many different tests.

The Practicing Physicians' Advisory Council (PPAC) explored this problem and recommended that HCFA establish panels that would be uniform for HCFA, uniform for the doctors ordering the tests, and uniform for the laboratories billing for them. This recommendation would have addressed the problem in a relatively straightforward manner.

However, under the new rules, physicians and laboratories must document the "medical necessity" of each lab test ordered. This requirement will impose massive new record-keeping requirements on the physician community. It is also unreasonable from the perspective of clinical medicine. Laboratory testing is often a tool to provide a missing piece of the medical puzzle. Our patients do not always arrive on our doorsteps with a known diagnosis. A patient does not usually come into an office and say, "Doctor, test me because I have lymphoma." But, she might complain of fatigue. How is the physician to prove medical necessity when ordering tests on a patient who says she's tired? Moreover, patients often have multiple disease processes occurring simultaneously or are borderline for one or more diseases. It is simply not appropriate for the Medicare program and its carriers to second-guess a physician's professional judgement. If physicians are required to reduce the number of tests ordered, or confine the tests ordered to a specific disease process, the opportunity for early detection will be diminished.

As with CLIA and so many other standards in the Medicare program, these regulations were inspired by isolated, outlier problems and subsequently expanded by into massive, costly burdens that punish the entire medical community. The waste, cost shifting, and lost patient time resulting from these burdensome regulations should be reined in to create savings in Medicare and for beneficiaries.

Medicare and Malpractice

Medical liability should also be included as part of comprehensive Medicare reform, for it is one of the more pressing health care problems confronting physicians today. The malpractice crisis contributes significantly to cost and quality problems that plague our health care system. Malpractice also figures directly into Medicare expenditures as a factor in determining physician payments under the fee schedule. In a recent survey of our membership, members ranked meaningful malpractice reform as their number one legislative priority.

The Academy supports federal tort reforms including:

- a $250,000 limit on non-economic damages;
- reducing awards by the amount of compensation from collateral sources;
- allowing periodic payment of awards of $100,000;
- limiting attorneys' contingency fees;
- replacing joint and several liability with proportionate liability among the defendants in a case ;
- a modified statute of limitations;
- mandatory and binding alternative dispute resolution (AD) systems;
- requiring an expert affidavit signed by a specialist who practices in the same medical specialty as the defendant; and
- the use of approved clinical guidelines as an affirmative defense.

Conclusion

Improving the Medicare fee schedule, reforming Medicare GME support, retargeting underserved bonus payments, easing regulatory burdens and paperwork, and imposing rationality and limits on the medical liability system, perfecting the Medicare risk contract program may not, at first glance, seem to be comprehensive Medicare reforms or obvious paths towards federal deficit reduction. But, taken separately or jointly, each of these recommendations will enhance the availability of primary care, and enhancing the availability of primary care is the **only** factor that has been shown to produce savings in the Medicare program. We urge you and your Ways and Means colleagues to give these programmatic changes equal consideration with spending reductions. Above all else, we urge you to consider Medicare reform through the prism of a rapidly changing medical marketplace and populace--an environment that requires greater support for primary care training and services.

Thank you for your consideration of our views. The Academy would be delighted to work with you on any of these issues.

Statement of the
American Academy of Ophthalmology
for the
House Ways and Means Committee
Health Subcommittee
hearing on
Medicare Reform and Innovation

Mr. Chairman and members of the Committee:

My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore, Maryland and the Secretary for Federal Affairs for the American Academy of Ophthalmology.

Ophthalmologists are physicians who provide primary and comprehensive medical and surgical eye care. The Academy is made up on nearly 20,000 ophthalmologists -- over 90-percent of the ophthalmologists in the United States.

My statement will focus on trends in Medicare spending reductions, proposals creating so-called "centers of excellence" and the need for significant reform of the Medicare program. I am pleased to have the opportunity to present this on the Academy's behalf.

The American Academy of Ophthalmology believes that all Americans should have access to quality health care including appropriate and affordable eye care. We believe that an appropriate level of eye care is necessary in order to promote general well-being, independent daily functioning, enhanced quality of life and meaningful economic productivity.

As we grow older, our bodies undergo significant changes. The visual system is no exception. Many disorders of the eye are associated with the aging process. In fact, its is not uncommon for Americans age 65 and older to experience significant vision problems. Consequently, ophthalmologists and our patients have a strong interest in maintaining the strength and integrity of the Medicare program -- the nation's most important provider of health care services for older Americans.

MEDICARE TRENDS

The Academy is concerned about reports suggesting Congress is considering cutting the Medicare program by $20-$40 billion over the next five years.

Regrettably, the Medicare program is, historically, one of the first programs to be targeted when Congress seeks budgetary savings. Since as far back as the Reconciliation Act of 1986 and including the budget acts of 1987, 1989, 1990 and most recently 1993, the physicians who treat Medicare patients -- the nation's oldest and most ill -- have had reductions in their reimbursements.

To date, these reductions have not had a significant effect upon the accessibility or quality of Medicare services. The concern remains, however, that if arbitrary budget goals continue to drive payment policies, the level of care provided under Medicare may eventually erode. We urge Congress to be mindful of this trend and its implication for the well-being of the nation's senior citizens.

"CENTERS OF EXCELLENCE"

Along with the Medicare reductions, the Academy is concerned about the creation of HCFA-administered schemes to achieve additional budgetary savings. To date, many of these schemes have been thwarted by Congress. The Academy is concerned about one proposal, in particular, the so-called "centers of excellence."

Under the typical "centers of excellence" proposal, the Federal government would centralize with a select group of urban providers and their facilities much of the cataract surgery, coronary artery bypass graft (CABG) and other selected surgical procedures performed in an area. The Federal government would make "rebate" payments to the "center's" patients as a means of drawing the patients into the facility and creating high-volume for the selected providers.

The Academy strongly supports patient access to providers and facilities of superior quality such as academic medical centers, teaching hospitals and other similar facilities. The "centers of excellence" should not be confused with such facilities. The "centers" result from the Federal government intervening in the health care market place in an effort to secure additional budget savings. Instead of ensuring patient access to high quality care, these "centers" represent a threat to quality care, market-based competition, and rural health care.

The Academy strongly opposes the concept of "centers of excellence."

Quality Problems

Despite being called "centers of excellence," the proposal typically includes no mention of quality standards or standards for "excellence." The "centers" are selected on the basis of cost -- through a competitive low-bidder process -- not on the basis of quality. Patients could be misled into believing that their surgical outcomes would be improved because their surgery took place in a marketed "center of excellence" instead of in a community-based facility.

In truth, "excellence" is already widespread in procedures such as cataract surgery. The Agency for Health Care Policy and Research (AHCPR), an arm of the Department of Health and Human Services, has determined that the success rate for the procedure is 95-percent. It is highly unlikely that centralization in low-bidder facilities with no quality oversight would improve on this success.

Today's community-based ophthalmologists follow their patients over the patient's lifetime. These ophthalmologists are aware of the patient's medical history and are aware of conditions such as diabetes and other systemic problems. This knowledge allows the physician to make appropriate clinical decisions that ensure quality patient care.

The government's intrusion in the health care market place will splinter this long-term physician-patient relationship. As a result of misleading marketing as a provider of "excellence," patients will be drawn out of their long-term relationship at a time when appropriate clinical decision-making is most critical -- when surgery is necessary. The quality of care will suffer needlessly as a result of this disruption.

Competition and Access Problems

Typically, the "centers" proposal excludes rural providers from competing to be "centers of excellence." The language setting up the "centers" specifies that in order to be a designated facility, the "center" must be in an urban area as defined by the Social Security Act. As a result of this language, rural providers, regardless of the quality of care they provide, are excluded from even competing for the designation.

Moreover, by locating these "centers" only in urban areas, the Federal government would create access problems for patients in rural and other underserved areas. Through the marketing of a facility as a "center of excellence" and the Federal government's "rebate" payment, patients would be encouraged and, in effect, paid to leave their community-based providers in rural and underserved areas and travel to an urban "center" for care. This exodus of patients from providers in rural and underserved areas could force many providers to relocate in order to maintain their practices. Patients remaining in the underserved areas could be left with limited access to providers.

Necessity of Care Problems

The "centers of excellence" could result in significant necessity of care problems.

The community-based ophthalmologists, providing comprehensive eye care over the long-term have assessed the patient's visual functions and understand the patient's visual needs, i.e., the patient may read extensively or drive a truck for a living. With this knowledge, the physician can work with the patient to decide if surgery is necessary. Surgery is offered as an alternative only when it is in the patient's best interest. There is little incentive to perform a procedure prematurely.

By contrast, the providers at the "centers of excellence" do not have long-term relationships with their patients. The "centers" can succeed only if their low-bidder fee is offset by an increase in surgical procedures performed. In effect, this requirement for volume creates a government-endorsed incentive to perform surgery.

The threat of inappropriate care is further exacerbated by the rebate payment provided to patients who undergo surgery in the "centers." The Academy questions whether the Federal government should be paying individuals to receive surgical care.

Ethical Problems

Through the "centers", the Federal government would make a "rebate" payment to the patients who received care at the facility. It is our understanding that the purpose of the payment is to entice additional patients to receive care from the Federally selected providers and their facilities. Currently, such "rebate" payments or "kickbacks" are illegal under the Medicare program because the government feels they may induce unnecessary care. We urge Congress to consider the implications of allowing patients to be paid to use government-endorsed providers.

REFORM OF MEDICARE

The Academy is very concerned about discussions in Congress regarding significant reductions to the Medicare programs. We are equally concerned about schemes such as the "centers of excellence" whose proposed existence is veiled in quality terms, yet, in truth, is only another attempt at reducing Medicare spending.

The issue Congress must address is what approach should be pursued to ensure that the Medicare program is able to respond to the needs of current and future beneficiaries. While there are many approaches which can be taken, history should tell us that there is one which has proven to be ineffective -- reducing Medicare spending through physician payment cuts. Despite recurring physician payment cuts, Congress still finds itself wrestling with the Medicare program. It should be clear that the continued targeting of physician payments will not cure the fundamental problems which ail the Medicare program. In fact, it has been argued that just the opposite may occur. The Physician Payment Review Commission (PPRC) has expressed concerns about targeting physician payments. The PPRC stated the following in its *Annual Report to Congress 1994*:

> Although the growing disparity between Medicare and private payment rates has not yet caused measurable reductions in access, further divergence in those rates would increase the risk of adverse effects on access. The Congress should be cautious about policies that will further widen the gap through additional constraints on Medicare payment rates.

The Academy urges Congress to look beyond physician payments and examine the Medicare program in its entirety. Already, some members of the Senate and this body have proposed innovative changes to the structure and function of the program. Similarly, the American Medical Association has made some recommendation regarding a "transformation" of Medicare. We encourage Congress to vigorously examine these proposals. These recommendations may represent an important first step toward ensuring a viable Medicare program.

Thank you for your attention to these issues. We appreciate this opportunity to comment on the Medicare program.

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 37,000 member professional association of respiratory care practitioners, welcomes the opportunity to submit written testimony on the House Ways and Means Committee's February 6, 1995 hearing on *"Controlling Costs and Improving Care of the Medicare Program"*.

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with deficiencies, abnormalities, and diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe---all often cared for by the respiratory care practitioner.

The AARC shares the Congress' concern at the increasing costs of the Medicare program. We believe that, unless fundamental changes are made to the Medicare program, the cost escalation will continue until the entire system reaches crisis proportions. We believe, however, that an in-depth analysis as to the underlying causes of the increases must be made prior to implementing changes that might inappropriately curtail the use of alternate care site services as provided by nursing homes, rehabilitation facilities, and home health care entities. The demographics of the elderly population, the advances in medicine and technology, and the increasing financial pressures from institutions to discharge patients into other less costly care sites must be considered when determining the causes of the increases in the use of alternate care services.

As advocates of the respiratory care community, the AARC and its members are acutely aware of the medical and clinical advances in the provision of respiratory care medicine, which now permits the pulmonary-restricted patient other pathways to receive the necessary evaluation care and treatment of their illnesses and diseases. For example, outpatient pulmonary rehabilitation has given many chronic lung diseased patients the ability to continue to lead productive lives at home. Pulmonary rehabilitation programs have greatly reduced hospital admissions, readmissions, and emergency room visits for asthmatics.

As another example, ventilator-dependent patients who, twenty years ago, may never have survived or, at very best, be left totally hospitalized can be cared for in a less acute care site such as a nursing home or even in the home. Many of these patients can be fully or partially weaned from the ventilator and lead productive lives provided they have access to respiratory therapy. Furthermore, the cost-effectiveness of respiratory therapy in the alternate care site has been demonstrated through study after study. Attachment No. 1 provides a summary of this cost information. If these patients who medically must have respiratory therapy services can find the services provided in a less expensive care site, then hospital care can be curtailed and costs reduced.

A 1993 Perspective Payment Assessment Commission report states the following (page 120):

> **"Taking one DRG, No. 483, tracheostomy, the most costly DRG which is most often performed to supply ventilator support, cost the Medicare program $2.6 billion per year or $76,522 per patient."**

If only a small percentage of these patients were to be transferred to a less-intensive care site, such as the nursing home, then cost savings to the Medicare program would be significantly reduced. Unfortunately, many of these patients are unable to be discharged to the nursing home because of outdated Medicare rules that were implemented well over twenty years ago when few respiratory-impaired patients left the hospital.

For the last two decades, the Medicare program has strictly interpreted a regulation that permits only respiratory therapists employed in a hospital, with which there is a transfer agreement in place, to provide Medicare-covered extended care respiratory therapy services in the nursing home. The restricted nature of the rule ties the hands of a nursing home facility in its ability to seek out other qualified respiratory therapy practitioners.

Even respiratory care practitioners who could be employed directly within the nursing home would be considered unreimbursable under the Medicare program.

This antiquated ruling must be lifted for several reasons. Nursing homes are unable to avail themselves of the competitive market place by having the ability to negotiate the best price for professional respiratory care services. The transfer hospital provides the only avenue from which nursing homes may find Medicare-covered respiratory therapy services. Skilled nursing facilities (SNFs) wishing to hire a respiratory therapist directly or under arrangements will find their services unreimbursable. With no competitive market place from which to negotiate the best and lowest cost of the RCP services, the Medicare program may be reimbursing at an inappropriately high cost for these services.

Secondly, some nursing homes may be geographically located a great distance away from the transfer hospital, and respiratory care personnel may be unavailable to travel the distances necessary to make the required visits (this is particularly true in rural areas). Under these circumstances, pulmonary patients may simply be readmitted to the hospital for lack of access to the appropriate care. Another consideration is that physicians are reluctant to discharge their respiratory patients into a facility if the necessary respiratory care is not provided or covered in the nursing home by qualified respiratory personnel; thus requiring the patient to remain in the costly hospital setting.

We would urge Congress to lift the restrictive hospital transfer agreement requirement and permit skilled nursing facilities to find the most appropriate and cost-effective way to provide medically-appropriate and prescribed respiratory care services to the Medicare nursing home patient. We would also request that, as Congress scrutinizes the Medicare home health benefit and Medicare-covered rehabilitation services, they bear in mind that respiratory care provided in these settings are cost-effective alternatives to hospital care.

COST-EFFECTIVENESS OF RESPIRATORY CARE

Increased Need for Respiratory Care Outside of the Acute Care Hospital

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with deficiencies, abnormalities, and diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe---they are all often cared for by the respiratory care practitioner.

Home care services have proven to be an integral part of the health care delivery system and a cost-effective alternative to expensive acute care hospital stays. The aging population, the spread of AIDS and tuberculosis, the increasing incidence of asthma, and advances in medical technology allowing technology-dependent patients to lead more productive lives outside the hospital, will increase the need for the services of trained and educated respiratory care practitioners. Respiratory patients will continue to be discharged from the hospital still requiring care, thereby increasing the demand for respiratory care services in alternate sites.

Overall, government health care policy has not kept pace with the advancement of medical technology and procedures. In particular, this has been the case for respiratory care services. When the Medicare/Medicaid program was first developed, respiratory care was fully recognized as a viable component of hospital services. Coverage and reimbursement for this service in the hospital have never been in question. However, Medicare/Medicaid policy has barely advanced in the past 25 years for respiratory care services rendered outside acute care settings. The scope of respiratory care services has developed significantly beyond the hospital setting. Where respiratory patients were once confined to a hospital bed, the same patients may now be cared for in a skilled nursing facility or in the patient's own home. It is the respiratory care community's recommendation that Congress recognize the role that respiratory care plays in the provision of cost-effective health care in alternate sites.

Respiratory Rehabilitation: A Cost-Effective Alternative

The purpose of rehabilitation is to ameliorate physical and cognitive impairments resulting from illness or injury, and to restore or improve functional ability so that individuals can return to work and lead independent and fulfilling lives. Pulmonary rehabilitation is designed to stabilize or reverse the effects of pulmonary diseases, such as emphysema, bronchitis, or chronic obstructive pulmonary disease (COPD) (i.e. those suffering from a degenerative disease of the lungs). One federal program, the Black Lung Program, has, since 1978, recognized the importance of structured outpatient pulmonary rehabilitation programs. The Coal Mine Procedure Manual states:

> "Further, DCMWC (Division of Coal Mine Workers Compensation) believes that properly administered pulmonary rehabilitation will reduce the need for future medical treatment, which would eventually prove more costly to the program."

Respiratory Care Saves Money

The scientific evidence on the cost-effectiveness and efficacy of providing respiratory care in alternate care sites continues to grow. The studies documenting cost-effectiveness of respiratory care have varied in methodology, scope, and time frame. The conclusion, however, is still the same: **respiratory care saves money.**

- A 1991 Lewin/ICF economic analysis focused on the effect of the availability of home medical equipment services on the cost of care for patients in three separate diagnostic categories. One of the categories studied was patients suffering from COPD. Lewin/ICF determined that $520 per patient per episode would be saved if a COPD patient was to receive care in the home rather than in the hospital. With an estimated patient population of 93,000 COPD patients per year, savings to the health care system amount to over $48 million per year.

- A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. The survey estimates that there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated $789 per patient per day. This totals over $9 million a day! Once a patient is medically able to be discharged, it takes an average of 35 days to place a chronic ventilator-dependent patient in an alternative care site such as the home or skilled nursing facility. That translates to an excess of $27,000 per patient in unnecessary hospital costs. Outdated reimbursement policies, which limit patients' access to respiratory care services outside the hospital, contribute to discharge delays and their subsequent excess cost.

- In the early 1980s, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients, who received home respiratory services from a qualified respiratory therapist. The results of the study shows that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for those patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled $1,097,250 (1980 dollars).

- A 1982 conference headed by former Surgeon General C. Everett Koop on home care alternatives resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than $15,000 per patient per month. Over the 34 month period of the pilot program, $3.1 million in savings were realized due to the availability of home care for these children.

- A 1991 Illinois-based study on ventilator-dependent infants receiving home respiratory care versus hospital-based care saved the state over $4 million during the four-year course of the program.

- A 1989 consensus conference co-sponsored by the AARC, the Food and Drug Administration (FDA), and the Health Resource Services Administration (HRSA) (attended by representatives from more than 60 national organizations and associations) studied the problems associated with the introduction of respiratory care equipment into the home. Practitioners, consumers, and representatives of the federal government that recommended that third-party reimbursement policies should allow home-bound respiratory patients to receive, when necessary, care from respiratory professionals.

- Aetna Life & Casualty developed an Individual Care Management Program for patients suffering from catastrophic illness. The following chart summarizes cost-effectiveness data for home care for these individuals:

Cost Per Month of Hospital Care Compared to Home Care, Selected Conditions

Condition	**Cost of Hospital Care**	**Cost of Home Care**	**Dollar Savings**	**Difference**
Infant born w/breathing & feeding problems	$60,970	$20,209	$40,761	66.8%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$ 9,153	$ 6,589	41.9%
Patient requiring respiratory support	$24,715	$ 9,267	$15,448	62.5%
Oxygen-dependent children with a tracheostomy	$12,236	$ 5,304	$ 6,932	56.7%
AIDS patient care	$23,190	$ 2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%

- Norwalk Hospital in Connecticut conducted a four year study to evaluate the effectiveness of a hospital-based home care program for patients with severe COPD. A comprehensive home care service program was provided to 17 pulmonary patients who previously required frequent hospitalization. The COPD patients participated in a comprehensive respiratory home care program and showed significant decreases in the following:

Hospitalization Admissions	88 pre-program	53 on-program
Hospital Days	1,181 pre-program	667 on-program
Emergency Room Visit	105 pre-program	64 on-program

  Costs for hospitalization, emergency room visits, and home care fell from $908,031 to $802,999 resulting in a savings of $105,032 or $328 per patient per month over the course of 48 months.

- Several research studies conducted in the past several years have compared inpatient care to home care costs for a specific group of patients. The cost savings data for these studies is summarized in the chart below. The information has been aggregated at a monthly level for purposes of comparison.

Conditions	Per Month Hospital Costs	Per Month Home Care Costs	Per Month Dollar Savings
a. Ventilator dependent adults	$21,570	$ 7,050	$14,520
b. Oxygen dependent children	$12,090	$ 5,250	$ 6,810

(a) Bach, J.R., Intinola, P., Alba, A.S., & Holland, I.E., (1992). The ventilator-assisted individual: cost analysis of institutionalization vs. rehabilitation and in-home management. *Chest, 101* (2), 26-30.

(b) Fields, A.I., Rosenblatt, A., Pollack, M.M. & Kaufman, J. (1991). Home care cost-effectiveness for respiratory technology-dependent children. *American Journal of Diseases of Children, 145*, 729-733.

STATEMENT OF
AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN ORGANIZATION OF NURSE EXECUTIVES

The American Association of Colleges of Nursing (AACN), representing 464 baccalaureate and graduate nursing institutions, the American Association of Nurse Anesthetists (AANA), representing 26,000 certified registered nurse anesthetists, and the American Organization of Nurse Executives, representing 6,000 practice executives, urge that Medicare Graduate Medical Education (GME) funds presently going mostly to undergraduate nursing education be redirected for graduate nurse education. This innovation would provide a stable, on-going revenue source to expand the production of advanced practice nurses (APNs), a vital resource for meeting future Medicare population needs. A graduate nurse education (GNE) program is one that educates nurse practitioners, nurse midwives, nurse anesthetists, or clinical nurse specialists. These APNs are prepared as expert clinicians to deliver primary care and services supportive to primary care. They also manage chronic medical conditions and other concerns typical of Medicare beneficiaries. GNE programs are post - baccalaureate, advanced practice nursing programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state and/or regional accrediting body, and award a graduate degree.

In order to educate adequate numbers of skilled APNs who provide high quality and cost-effective services to Medicare recipients and others, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. Medicare uses GME monies for support of provider operated nursing and allied health programs. AACN urges that these nursing education GME monies be redirected to educate APNs.

We suggest the following Medicare changes regarding support for professional education at Medicare facilities:

1. Changing eligibility to include jointly operated programs.

Medicare reimburses hospitals for a portion of the costs of eligible hospital-owned or operated nurse education programs. In fiscal 1991, hospital operated undergraduate programs received $174 million in GME, according to Health Care Financing Administration data. Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed; educational cost of these new providers are, with one exception (nurse anesthetists), not covered by Medicare. **Consequently, eligibility requirements should be changed to those "jointly-operated" (provider-academic) programs incurring costs for support of APN education.** Providers eligible to receive reimbursement would have to meet all of the following criteria: must be eligible to receive Medicare Part A, incur clinical costs for the support of graduate nurse education programs, and have a written contractual agreement with the program's academic institution. Cost allocations for determination of Medicare's share of reimbursement would include student stipends, costs of nursing clinical faculty and supervision at the clinical site, and program expenses, all limited to that portion of the education taking place at the Medicare provider facility. Determination of the specific cost of education would be based on an appropriate ratio of faculty to students, and faculty and supervisory salaries. In part, that agreement will require the provider to issue both a voucher for clinical education costs and a clinical stipend to the APN student.

2. Clarifying of "provider" definition to include out - patient facilities.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery evolving beyond acute care to community based sites, ambulatory care facilities as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. It is critical to support these settings, because students must be exposed to a variety of places where people are getting care.

The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, health maintenance organizations, and public health departments. A broad definition of eligible training facilities is necessary to facilitate clinical training of the largest number of APNs in those sites that have the greatest need for these practitioners.

Most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are part of the cost of providing patient care because patients receive the benefit of the care delivered by graduate students and their faculty.

Under this proposal, all entities that incur clinical costs for support of APN education would have access to GNE funding for the portion of the cost attributable to the Medicare patient population. GNE funding would allow the allocation of resources for added clinical faculty to expand the number of APNs in training. APNs are precisely the type of health professional the Medicare populations will need for primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization or nursing home care. This would help eliminate the waiting lists which all graduate nursing programs are experiencing. Support of preceptors in the clinical sites would allow them to provide teaching and direct clinical supervision to the APN students as a planned component of their job responsibilities, rather than as an additional responsibility to their current workload. GNE support would also provide incentive to the practice sites to agree to take on students for clinical training.

Due to limited resources in many of these settings where patients are receiving care, most can only take on one or two APN students at any one time. This forces programs of nursing to contract with numerous sites in order to provide clinical training for students. Reimbursement to clinical sites for clinical faculty would allow the concentration of groups of APN students, providing economies of scale and improving efficiency of the training process. In addition, reimbursing clinical sites for training APN students recognizes the value of their services to patient care. With the number of specialty resident physicians likely to be reduced, these APNs will be delivering many of the services formerly performed by resident physicians, as well as nursing care. Acute care nurse practitioners who have graduated from programs such as these, are already assuming roles in a number of clinical sites.

The APN can be a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. Presently, costs of preparing the APN are borne almost entirely by programs of nursing and the students themselves, each with very limited resources. The Nurse Education Act (T. VIII of the Public Health Service Act), among other things, provides modest support (FY 95 = $45 million) for the didactic (non-clinical) part of the APN programs, but would not be redundant to the GME support.

At present, Medicare reimbursement for nursing education programs is limited by the "provider - operated rule," which directs most of the funding to diploma programs that produce entry level nurses. There are data indicating that the number of entry level nurses is adequate. There is a large gap, however, in the supply of advanced practice nurses. There have been five demonstration projects funded by Medicare to educate various types of advanced practice nurses. These projects ended in July 1994 and a report on the demonstration projects will be sent to Congress this summer. These projects show that Medicare dollars increased the recruitment and retention of advanced practice nurses at the facilities running the programs, created a skilled nursing facility, and improved the provision of nursing care. These programs suggest that more Medicare support for advanced practice nurses will greatly benefit the Medicare population and could help reduce Medicare costs through replacement of more costly professionals.

This is the time to shift GME funding toward the recognized great need for advanced practice nurses. Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Though the redirection of these funds for support to APN education requires no new Medicare expenditures, it is imperative that funding levels should not be reduced for those APN programs currently receiving Medicare support . Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of the changing health care workforce.

In order to quickly expand the numbers of these expert nurse clinicians, we need your help. We ask for your support.

GMEGNE.WM

American Association of Preferred Provider Organizations
AMERICAN ASSOCIATION OF PPOs

February 16, 1995

The Honorable Bill Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organization (AAPPO) appreciates the opportunity to comment on the issue of Medicare reform and innovation, the subject of your February 10 hearing. We respectfully request that this letter be made part of the official hearing record, as provided for in your January 30 announcement.

As you know, managed care plans have become the norm in the private sector. Sponsors of both commercially-insured and self-insured health plans increasingly offer managed care options to their employees, a trend driven by employee preference as well as cost savings. The Medicare program, in its continuing reliance on a fee-for-service model, is out of step with the rest of the health care market. Medicare beneficiaries, like the privately-insured population, should have a choice among plan options. In many cases, they may prefer a plan that involves less paperwork and ensures that care is coordinated among physicians and other providers.

Recent testimony by the Congressional Budget Office reflects AAPPO members' experience: managed care plans can achieve significant cost-containment success. We strongly urge you to incorporate this success in Medicare through increased use of managed care. PPOs deserve particular attention in that they already have a proven record of reducing expenses without restricting patient choice. Since much of the opposition to managed care in Medicare stems from fear of being coerced into consulting only specified providers, serious consideration should be given to a model that can address this concern without sacrificing either efficiency or quality.

PPOs are network-based managed care organizations created to facilitate a working relationship between physicians, hospitals, and other providers and health care purchasers or their administrators. Providers agree to deliver their services at competitively negotiated rates and prices and to comply with utilization management and quality assessment controls. A PPO is marketed as a product to employers and employees, as well as directly to insurance companies, which in turn market the network to their employer clients. Employees enrolled in a PPO plan retain the freedom to select their provider, but are given financial incentives to choose to receive care within the managed network.

PPOs have grown in prevalence and popularity in recent years. The consulting firm Hay/Huggins reports that a majority of employers with health insurance plans now offer a PPO option; a significant development in 1994 was the increased incidence of PPOs and other managed care models serving as the employer's **primary** health plan. In other surveys, employers report increasing use of managed care networks in their retiree and even in their international benefit plans.

AAPPO supports efforts to extend the Medicare Select program to all 50 states, and to make it permanent. Medicare Select allows beneficiaries to enroll in private health plans that compete to provide low-cost, high-quality care. It offers a low-commitment, low-threat introduction to managed care for beneficiaries without previous experience, and in time may provide a comfortable transition to choosing managed care for basic as well as supplemental Medicare benefits. Medicare Select can deliver high quality care at a lower premium cost to beneficiaries, and produce savings to the government at the same time.

Beyond the specifics of Medicare Select, AAPPO would like to work with the Subcommittee and the Administration to revise the regulations and payment methodologies that currently restrict the use of managed care in Medicare, and to develop a real, workable PPO option for Medicare beneficiaries nationwide. Thank you for your attention, and for including our views in the hearing record.

Sincerely,

Gordon B. Wheeler

Gordon B. Wheeler
President & Chief Operating Officer

cc: Members of the Subcommittee
Charles N. Kahn
David Abernethy

ACA
AMERICAN CHIROPRACTIC ASSOCIATION

STATEMENT SUBMITTED TO
THE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
ON
"MEDICARE REFORM AND INNOVATION"
FEBRUARY 10, 1995

Introduction

The American Chiropractic Association (ACA) is pleased to submit this statement to the subcommittee on the issue of reforming the Medicare system. As the world's largest chiropractic organization, ACA has long spoken for the profession on a range of issues before Congress, and have in fact frequently testified before this subcommittee on issues related to Medicare and health care reform. Our over-arching goal in our dialogue with the subcommittee and the Congress has always been to advance Americans' freedom to choose the high quality health care services lawfully performed by doctors of chiropractic (D.C.s) under the authority of State law. It is that same goal which brings us to deliver this statement today.

We are pleased that the subcommittee has chosen to explore possible methods to reform and improve the Medicare system. We have noted with enthusiasm the statements of Speaker Gingrich and others in Congress about the need to offer greater choices to senior citizens in Medicare and look forward to being constructively engaged in the process by which those choices are expanded. Reforming the system to expand beneficiary choice and increase competition among health care providers will surely benefit the system, and advocacy of such improvements is an extremely high priority for the ACA. We are confident that, if given the genuine freedom to choose their health care provider, Medicare beneficiaries will freely avail themselves of the services of doctors of chiropractic, just as over 18 million regular chiropractic patients do every year.

Unfortunately, with the exception of a single narrowly defined service, Medicare beneficiaries are denied any real ability to choose a chiropractor. As a result, both beneficiaries and the program itself have been deprived of the potential health benefits and cost savings that full coverage of chiropractic services could produce. The program also forgoes any savings that might result from full and open competition between chiropractors and other Medicare providers.

While we do not suggest that resolving the specific problems related to the chiropractic portion of the program will solve all the problems plaguing Medicare, the issues we raise are symptomatic of a system needing to reaffirm its commitment to patient freedom of choice. Therefore, we hope that the subcommittee, and Congress as a whole, will address the issues that we raise within the context of overall Medicare reform.

Patient Freedom of Choice Guaranteed

The denial of patient choice that is manifest in Medicare's limited chiropractic benefit flies in the face of the "freedom of choice of provider" guarantees established at the inception of the Medicare program in 1965. The Social Security Act, which authorizes Medicare, clearly states that:

> "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate in this title if such institution, agency, or person

undertakes to provide him such services."[1]

Unfortunately, as it pertains to the services of D.C.s, limitations on Medicare coverage frustrate the freedom of choice goal that is explicit in the statute. Non-coverage of chiropractic services establishes an economic barrier which dilutes beneficiaries' real freedom to choose and negatively governs patients' actions in seeking health care services. Any legislative effort to improve the current system should, in our view, reassert Medicare's fundamental guarantee of a patient's right to select the health care provider of their choice, including a chiropractor.

Medicare's Treatment of Chiropractic Services

Despite Medicare's clear promise of patient "freedom of choice," in 1973 Congress approved an extremely limited chiropractic benefit that, for all practical purposes, restricts patient access to chiropractors. As many senior members of the subcommittee are aware, Medicare does not cover the full range of services that D.C.s are licensed to provide. In fact, only a single service performed by a chiropractor -- manual manipulation of the spine -- is covered. However, due to an overly-narrow construction of the statute by HCFA and its predecessor agency, it is difficult for beneficiaries to obtain even this extremely limited benefit.

As currently drafted, the Medicare statute defines doctors of chiropractic as 'physicians', but only for the purposes of "manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist)..."[2] This definition defines the parameters of covered chiropractic services under the program. As prescribed under the definition, Medicare also *requires* that a diagnostic x-ray be performed prior to initiation of the manual manipulation service. However, while the x-ray is mandatory, if performed or ordered by a D.C., it is not deemed to be a covered service. This restrictive interpretation of the benefit was rendered over twenty years ago and has not been liberalized since.[3]

The practical result of this outdated definition is to deny Medicare beneficiaries any real choice of most of the services chiropractors are licensed to perform. It offers them an extremely limited benefit that is both insufficient for the delivery of proper care and difficult to obtain.

These restrictions on Medciare's chiropractic benefit limit patient choice in two ways. First, with the exception of manipulation of the spine, no services that D.C.s are licensed to provide under state law are available to beneficiaries. The vast majority of services that D.C.s normally provide simply are not covered. Second, the requirement of a non-covered x-ray means that chiropractic patients are either forced to pay for the x-ray themselves -- a cost that many cannot afford -- or are inconvenienced by having to seek the x-ray service from some type of provider other than their D.C. Either way, the non-covered x-ray constitutes an additional layer of bureaucracy that discourages beneficiaries' real choice of provider.

ACA's "Chiropractic Patient Freedom of Choice" Proposal

ACA would urge Congress to lend a measure of common sense to this arcane and outdated portion of the program by granting Medicare beneficiaries equitable access to health care services provided by doctors of chiropractic. *Therefore, we call for enactment of a "chiropractic patient freedom of choice provision" that would grant Medicare beneficiaries access to any service presently covered under Medicare that chiropractors are licensed to perform under state law.*

In recognition of the need to control Medicare costs, our proposal *would not add or require coverage of a single new service under the program.* Rather, it would simply provide beneficiaries access to *currently covered* Medicare services when performed by D.C.s. For example, Medicare currently covers diagnostic x-ray services when performed by medical radiologists. Under the ACA plan, patients would receive coverage for that same service when furnished by a D.C., since the performance of x-rays falls within a D.C.'s legal scope of practice. Wherever there is overlap between the services Medicare covers and the services D.C.s are licensed to perform, beneficiaries would enjoy the ability to obtain care from a chiropractor. The proposal would expand beneficary access to cover services while at the same time significantly improving their choice of licensed health care providers.

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[1] Section 1802 of the Social Security Act.

[2] Section 1861(r)(5) of the Social Security Act.

[3] 39 Federal Register, No. 155, August 9, 1974.

The concept embodied in this proposal is nothing new. A majority of the states have adopted similar "health provider freedom of choice" laws where they have expanded access to care and spurred the competition among providers that helps hold down costs. It is time for Medicare to "get in step" with the health care innovations taking place in the States by adopting a similar patient freedom of choice proposal.

Cost Benefits of Chiropractic Care

It has been known for years that D.C.s provide cost effective health care services. By granting Medicare enrollees access to these services, the program stands to reap significant savings from lower costs of treating many common health care conditions. The majority of the care that D.C.s provide involves treatment of neuromusculoskeltal (NMS) disorders -- over 88% according to ACA's 1994 Annual Membership Survey. Research shows that chiropractors typically treat these conditions much more cost effectively than do other providers. For example, a recent study of found that, for treatment of common NMS conditions treated by all types of health providers, "chiropractic users tend to have *substantially lower* total health care costs."[4] (emphasis added.) Follow-up research has substantiated these initial findings.[5]

These findings should come as no surprise. D.C.s treat patients in a conservative manner without the use of expensive drugs of surgery and have historically helped patients avoid the expensive hospital setting.

ACA has shared numerous other studies demonstrating chiropractic cost effectiveness with the subcommittee in the past, and would be delighted to do so again at your request. However, it is important to emphasize that the cost savings attributable to chiropractic care are especially notable in the treatment of low-back pain -- a health care condition that will afflict most of the population at some time in their lives and for which costs to society range from $20 to $50 billion a year.[6]

Independent empirical research indicates that chiropractic is by far one of the best forms of care available for low back pain. According to a recent study commissioned by the Ontario Ministry of Health, "there is an *overwhelming* body of evidence indicating that chiropractic management of low-back pain is *more cost effective* than medical management."[7] (emphasis added.) In fact, the researchers involved in this study were so impressed with the effectiveness of chiropractic, that they recommended government policies actively encourage patients with low-back pain to visit D.C.s as the first course of treatment.

While these and similar findings have been available for a number of years, one of the strongest endorsements for treatment of low-back pain through chiropractic methods has been provided by the U.S. Agency for Health Care Policy and Research (AHCPR). In the agency's recently released guideline on the treatment of low-back pain, spinal manipulation was found to be a *recommended and effective* form of care. While the guideline did not specify a preference for any particular provider of spinal manipulation, it is well known that doctors of chiropractic are the leading experts in this particular treatment modality. In fact, they are virtually the sole practitioners of this care, delivering 94% of all the spinal manipulation services rendered in this country.[8]

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[4] Stano, M, et al., Journal of American Health Policy, Nov./Dec. 1992, Vol.2, No.6.

[5] Stano, M., Journal of Manipulative and Physiological Therapeutics, Vol.17, No.7, September 1994.

[6] U.S. Department of Health and Human Services, "Acute Low Back Problems in Adults," Clinical Practice Guideline, Number 14, AHCPR Publication No. 95-0642, December 1994.

[7] Manga, P., et al, The Effectiveness And Cost Effectiveness of Chiropractic Management of Low-back Pain, Pran Manga & Associates, Inc., Ottawa, Ontario, August 1993.

Undoubtedly, low-back pain is a problem that has a huge impact on the health and quality of life of many elderly Americans. In light of all the evidence, including the AHCPR's new clinical guideline, there is more reason than ever to revise Medicare's antiquated and biased policies that hinder the elderly's ability to obtain health care services from D.C.s. Under ACA's "chiropractic patient freedom of choice provision," Medicare beneficiaries could once and for all freely avail themselves of this cost effective form of care.

Managed Care

We are aware that much of the debate on Medicare reform thus far has focused on expanding the delivery of covered benefits through managed care organizations (MCOs). Because our commitment to patient freedom of choice extends to a patient's ability to choose types of plans, we believe that health maintenance organizations and other MCOs should remain an option for the elderly. However, we feel it is unfair to present beneficiaries with undue dis-incentives for electing to remain in the traditional fee-for-service portion of the program. Many elderly wish to retain the freedom-of-choice that is the underpinning of fee-for-service health care and financial arrangements should not discourage them from exercising this option. However, if a beneficiary elects to enroll in a Medicare HMO, we believe that Medicare has an obligation to fully inform them about what that choice means, especially as it relates to the inability to freely choose one's health care provider. If beneficiaries wish to accept limited provider choice, then that is their right. However, they should not be deluded about the fact that they will relinquish their ability to select a health care provider from outside of a narrowly drawn list.

As managed care's emphasis on containing costs has grown, the ACA and many other health care organizations have become increasingly concerned about fundamental issues of consumer choice, access and quality. Health care consumers, including Medicare beneficaries, expect and deserve a certain minimum level of protection against the managed care industry's shortcomings in these areas. The public desire for these protections was especially in evidence during last year's health care reform debate when several health reform bills contained important provisions designed to address these concerns.

The ACA's interest in this area has not abated. As a result, over the last several months, we have spearheaded a coalition of health care provider and consumer organizations in developing a legislative package designed to improve consumer choice and health care quality under managed care settings. Almost complete, the package seeks to improve the current system by ensuring that health plans have an adequate choice and mix of providers; by establishing quality assurance mechanisms; by improving the quality and availability of consumer information; and by creating 'due process' procedures for both providers and consumers. Similar provisions received considerable bipartisan support in the last Congress and we have attempted to 'bundle' these concepts into a single legislative package that we hope will receive serious consideration this year. We will transmit this proposal, along with a list of supporting organizations, to the subcommittee once it is finalized in the near future.

In our view, these protections should be extended to enrollees in all managed care health plans, including those enrolled in Medicare HMOs. We hope that the subcommittee will give serious consideration to this package of consumer and provider friendly provisions as part of any effort to encourage further beneficiary enrollment in managed care plans.

Lastly, before further encouraging the elderly to enroll in managed care, Congress should revise the rate setting methodology utilized in the risk contract program to ensure that cost savings are being realized. As the committee is all too aware, current policies under which

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[8] Shekelle, PG., et al., The Appropriateness of Spinal Manipulation for Low Back Pain: Project Overview and Literature Review, RAND Corporation, Santa Monica CA, 1991.

Medicare HMOs are paid result in overpayment of between 6 and 28 percent.[9] This means that Medicare is actually losing money by enrolling beneficiaries in managed care plans. It makes little sense to encourage the elderly to enroll in these plans if doing so consistently costs the program more than if these patients remained in fee-for-service Medicare. Clearly, these glitches should be corrected prior to moving more rapidly in this direction.

Conclusion

The current chiropractic benefit under Medicare was enacted over twenty years ago and reflects an antiquated and ill-informed view of the role of doctors of chiropractic (D.C.s). It is an outdated vestige of an era when patient choice was subordinated to other less lofty interests. It is time to discard old policies which serve only to impede beneficiary choices. ACA's "patient freedom of choice" proposal seeks to expand the beneficiaries' choice -- a goal we believe that this subcommittee shares with us. We urge the subcommittee to adopt our proposal as part of any Medicare reform it pursues.

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[9] U.S. General Accounting Office, Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs, September 1994.

STATEMENT OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS TAX DIVISION

The American Institute of Certified Public Accountants (AICPA) is the national, professional organization of CPAs comprised of more than 320,000 members who advise clients on federal, state and international tax matters as well as prepare income and other tax returns for millions of Americans. Our members provide services to individuals, not-for-profit organizations, small and medium-size businesses, as well as America's major businesses, including multi-national corporations. Many serve businesses as employees. It is from this base of experience that we offer our comments on the tax treatment of health insurance costs of self-employed individuals.

The decision in 1994 to postpone consideration of health care reform legislation has resulted, among other things, in the loss of a deduction by self-employed individuals for any health insurance premiums they have paid in that year. As part of the 1993 Omnibus Budget Reconciliation Act, when a number of other "expired provisions" were retroactively re-enacted (targeted jobs tax credit, low-income housing credit, employer-provided education and training expenses, etc.) and allowed to remain in the law past the end of 1993, the deduction for 25 percent of self-employed insurance premiums was terminated at the end of the calendar 1993. The committee reports noted that this provision should be considered in conjunction with forthcoming health care reform (as indeed it was, in virtually all the health care bills proposed during 1994).

Since, however, there were no health care changes in 1994, there was also no extension of the deduction for self-employed health insurance. This is a highly unfortunate result, and puts a significant penalty on the health costs of those who operate as proprietors, partners, or S corporation shareholder/employees, vis-a-vis those who are employees of C corporations.

Pending whatever changes are made to health care legislation in the future, we think it critical that Congress re-establish the right of self-employed persons to receive even that limited deductibility for health insurance costs that they enjoyed before 1994. We do recognize that this provision, on a stand-alone basis, is a revenue loser for the government. Nonetheless, there remains a major issue of fairness for a significant part of the business community, and we would urge your attention to this matter.

As an organization that values simpler approaches to tax legislation, we would greatly prefer to see action taken immediately, before the bulk of 1994 returns have been filed, rather than the added complexity of amended 1994 returns and refund claims that even a minor delay will cause. Still, we believe the self-employed business person has now – even with the best of congressional intentions – been further disadvantaged with respect to the cost of health care, and is entitled to a restoration of the deduction for the current year.

We appreciate your consideration of our views.

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

Mr. Chairman:

This statement is submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on the growth of cost under Medicare.

Our association is a national membership organization of rehabilitation facilities providing medical, vocational and/or residential services. Our membership includes over 300 rehabilitation hospitals and rehabilitation units in general hospitals. All of these are providers of inpatient rehabilitation services.

There is a critical need for reform of the current Medicare payment policy for PPS exempt rehabilitation hospitals and units. The present system is harmful to patients and providers alike and is wasteful for the Medicare program. No one - not HCFA, ProPAC, providers or consumers - defends the status quo. We urge reform of this payment system, and that it be thorough and immediate.

Defects of the Present System.

When the Medicare Prospective Payment System (PPS) was enacted in 1983 rehabilitation hospitals and units were excluded because the data used to develop that system did not account for cases with longer lengths of stay, including rehabilitation cases. Such facilities continued to be paid through cost reimbursement, subject to per-discharge rate-of-increase limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA limits were intended to be a temporary means of controlling costs pending adoption of a PPS. They are still in place 12 years later and have produced serious, and unintended, distortions in the delivery of rehabilitation services for the following reasons:

- TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that any increase in intensity of services or length of stay is likely to cause a hospital or unit to exceed its TEFRA limit.

- TEFRA limits place pressure on rehabilitation hospitals and units to cut average length of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients.

- New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Accordingly, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This encourages the development of new providers, which are reimbursed at much higher levels, and seriously distorts the positions of competitive providers.

- This system virtually prohibits the development of programs by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit, while encouraging the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.

- The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many legitimate costs.

How is the government hurt by these effects? First, because new hospitals are paid more, the system encourages capital spending. Second, the Medicare program is paying many new hospitals and units considerable amounts in incentive payments while not covering cost of service to many older facilities. This is a disservice to beneficiaries. Any system that so seriously distorts the allocation of payment with no regard for patients needs or services delivered will distort quality and availability of services.

Data available from HCFA for Medicare reporting years ending between October 1, 1992 and August 31, 1993 contained cost report information for 128 rehabilitation hospitals. Of these 67 were under their limit, 23 were over their limits and 38 had no limits (because they were new). Those facilities over their limits had an average cost per day of $562. Those under their limits had a cost per day of $559. Thus, presuming cost per day reflects intensity, there is no evidence of differing intensity of services. The average TEFRA limits for those with costs over their TEFRA limits was $11,122. The average for those under their limits was $15,267.

The difference in payment between these groups does not reflect a difference in services provided, but rather the vagaries of the Medicare system. The picture for rehabilitation units is similar.

Cost Reimbursement/TEFRA Should be Replaced by a PPS for Rehabilitation.

Prudent use of scarce resources and the interests of patients dictate that this system be replaced as soon as possible. Marginal changes in the TEFRA system will not, at least as it affects providers of rehabilitation services, eliminate its basic defects.

It should be replaced with a prospective payment system for PPS exempt rehabilitation hospital and rehabilitation unit services that makes payment based on patients' needs for services. By doing so Medicare payment will eliminate the bias in the present system against more complicated diagnoses (or cases) and treat all providers equally, thus removing the preferential treatment and incentives for new facilities.

Our association has sponsored research to fashion such a system. A research team at the University of Pennsylvania developed a patient classification system based on Functional Related Groups (FRG). This classification system includes age, diagnosis and functional ability on admission to rehabilitation. It predicts duration and intensity of rehabilitation services. The Health Care Financing Administration has issued a request for proposals to evaluate this system and to design a payment system based on it. We are encouraging and supporting this effort in every way possible.

The first law of governmental action is that research and analysis will expand to fill the time available. This is a major concern for us. The best evidence of this reality is the fact that in the Omnibus Budget Reconciliation Act of 1990 the Congress directed the Secretary of HHS to submit recommendations on reform or replacement of TEFRA by April 1, 1992. Almost three years after that deadline no such recommendations have been forthcoming. Hence, we believe that a statutory deadline for implementation of a PPS for rehabilitation is badly needed to force this matter to a conclusion.

Therefore, **we recommend** that any Medicare legislation considered this year include a provision setting such a deadline. We suggest that this be for cost reporting periods beginning on and after October 1, 1996.

Modification of Criteria for Definition of Rehabilitation Hospitals and Units.

Rehabilitation hospitals and units must meeting certain criteria established by regulation for exclusion from the Medicare Prospective Payment System. These are contained in 42 CFR 412.23. Among these is a requirement that not less than 75% of a provider's patients be in one or more of 10 diagnostic categories. These are:

* stroke;
* spinal cord injury
* amputation:
* major multiple trauma;
* fracture of femur (hip fracture):
* brain injury:
* polyarthritis, including rheumatoid arthritis;
* neurological disorders, including multiple sclerosis; motor neuron disease, polyneuropathy, muscular dystrophy and Parkinson's disease ; and
* burns.

This list was adopted from the practice of rehabilitation facilities in the 1970s. Over the past 20 years it has become increasingly common for rehabilitation hospitals and units to treat other patients with other diagnoses, including particularly those with pulmonary conditions, chronic pain, cancer and cardiac problems. The functional limitations of each of these, often post-surgery, can be improved through rehabilitation.

The present criteria for exclusion of rehabilitation hospitals and units from the Medicare PPS are established by regulations, not statute. For several years the rehabilitation community, through this association and otherwise, has urged HCFA to revise the pertinent regulations, to no avail.

We recommend that this subcommittee correct this problem by legislation by adding the above referenced four conditions to the criteria for exclusion.

We advocate this change for two reasons. First, it is important to a number of hospitals now excluded from PPS as long term care hospitals. Many of these function as rehabilitation hospitals, but are precluded from qualifying for exclusion from the PPS as such because they have significant numbers of patients in one or more of the four diagnostic categories we seek to have added to the exclusion criteria. The matter is increasingly critical for institutions that have reduced lengths of stay to try to mitigate financial damage from TEFRA limits.

ProPAC recently released figures showing that, on average, long term hospitals are reimbursed on about 75% of cost because of TEFRA limits. Enclosed is a schedule we prepared from HCFA data that indicates large TEFRA penalties for this group. As a practical matter the only way to reduce per discharge cost significantly is to reduce lengths of stay. But, long term hospitals have a floor of 25 days, beyond which is loss of exclusion. (The need for rebasing of TEFRA limits of long term hospitals is discussed below).

The logical course for such facilities is to be excluded from the PPS as rehabilitation hospital, but the provision of significant services to pulmonary, cancer, pain and/or cardiac patients is a barrier to doing so.

The second these conditions is important is the effect of current rules on institutions now excluded as rehabilitation hospitals and units. Those that operate programs for patients in the four conditions must constantly monitor their admissions in these categories to avoid going over 25%. Admissions should reflect the needs of patients and the current practice of rehabilitation in the field rather than such artificial regulatory considerations.

Need for Oversight of TEFRA Adjustment Process.

Section 1886(b) of the Medicare Act provides that a provider with operating cost over a TEFRA ceiling may seek administrative adjustment of its TEFRA limit by HCFA. The law requires that HCFA issue the provider a decision on a complete application within 180 days of its receipt and that a full explanation of the decision be provided to the applicant. The law also provides for assignment of a new base year for determination of TEFRA limits "which is more representative" of the reasonable and necessary cost to a hospital of providing inpatient services."

While the authority vested in the Secretary is sufficient to permit proper adjustment of limits to recognize changes in services and inequities between new and old providers, the adjustment process is flawed in its implementation.

It is beyond the scope of this statement to critique the administration of these provisions by HCFA. However, **we recommend that** the subcommittee examine this matter through oversight hearings, GAO inquiry or otherwise with respect to the following points:

- Timeliness of decisions. The statutory requirement for issuance of decisions within 180 days is routinely violated by HCFA, while filing requirements are strictly enforced against providers.

- Failure to use rebasing authority. HCFA has refused to use the authority to rebase providers, while acknowledging the disparity of treatment between newer and older providers.

- Inconsistency. Standards for adjustment are not applied uniformly, without explanation.

- Absence of explanations. While the law requires that a provider receive a "detailed explanation of the grounds" on which its application is approved or denied decisions often do not address issues raised and do not explain actions taken.

Interim Modifications of the TEFRA System Pending A PPS for Rehabilitation.

We recommend enactment of legislation to set October 1, 1996 for implementation of a PPS for rehabilitation hospitals and units. If a later deadline is adopted **we recommend** certain modifications to the TEFRA system as it is applied to such providers.

First, we recommend that there be an floor on TEFRA limits, set at 70% of the national average. Presently there are some rehabilitation hospitals and units with limits as low as $3,000, while the national average is over $12,000. These providers are required by Medicare coverage guidelines to provide the same levels of nursing and therapy services as other hospitals and units. Because Medicare coverage guidelines require similar services there should be some comparability of caps on payment. We suggest 70% of the national average TEFRA limit as a floor to provide relief to hospitals and units saddled with extremely low limits.

Second, we suggest that any new rehabilitation hospital or unit certified after date of enactment receive a TEFRA limit no greater than 150% of the national average. It is completely inequitable for the Medicare program to continue to reimburse new facilities at far higher rates than older ones - while both compete for staff and patients. The inequities presented by the widely varying limits of current providers will be eliminated only through adoption of a PPS. In the meantime, some small measure of sanity can be introduced into the system by capping limits for new facilities.

TEFRA Limits Should Be Recalculated on Contemporary Cost for Long Term Care Hospitals.

The serious distortions and inequities of the TEFRA system for rehabilitation providers can and should be solved by the adoption of a PPS for rehabilitation hospitals and units. We believe that the patient classification system discussed above provides a sound basis for doing so. Well over 90% of patients treated in rehabilitation hospitals and units fall into the classification categories represented by FRGs and payment for the balance can be easily computed through averaging and/or provision for outliers.

A PPS for rehabilitation will not, however, remedy the impact of TEFRA limits on long term care hospitals, except for those facilities that are recognized by the Medicare program as rehabilitation facilities. The sole criterion for exclusion of a long term care hospital from the PPS is maintenance of an average length of stay of over 25 days. The types of patients treated in this group of facilities vary widely and the patient classification system developed for rehabilitation does not apply to most of them.

The adverse effect of TEFRA on long term care hospitals has been profound. ProPAC reports that in fiscal years ending 1989 long term care hospitals as a class were reimbursed only 75% of cost by the Medicare program and in FY 1991 75% were over their TEFRA limits. This is because many such facilities were Medicare providers when the TEFRA system was adopted in 1982 and have limits based on base years that are not representative of current costs.

Exhibit A shows the position 75 long term care hospitals. These data are drawn from the HCFA PPS-IX Minimum Dataset and are the most current data so reported by HCFA. The cost reports contained in this data base are for fiscal reporting periods ending in the period 10/1/92-8/31/93.

In 1994 HCFA separately reported that there were 115 long term hospitals excluded from the PPS. This absence of 40 hospitals from the Minimum Dataset cannot be conclusively explained. It is likely that many are new facilities. To the extent that this is the case, they were not subject to TEFRA limits and would not be affected by rebasing of limits. Similarly, there would be no increased Medicare payment to these hospitals from rebasing.

These data show that the average TEFRA limit for facilities over their limits was only $11,181. For those under limits the average was $21,740. This is a huge difference, for which there is no sound public policy.

Since a PPS is not a prospect for this group of facilities **we recommend** rebasing of TEFRA limits to current cost. In the process incentive payment of providers under their TEFRA limits should be protected.

Future Initiatives.

The subcommittee's announced intention to consider alternatives to the present structure of the Medicare program is to be applauded. We are particularly concerned with the fragmentation of rehabilitation services due to current institutional definitions, coverage guidelines and division of services between Part A and Part B. Our association has several committees working to fashion proposals to address these matters and hope to submit further recommendations to your in the near term.

Our guide in this undertaking is continuity of care for patients and provision of services in the least restrictive and most cost beneficial environment, subject to the ultimate goal of maximum recovery of function and ability to live independently and productively.

Thank you for your consideration of the recommendations set forth above.

Attachment: Long Term Hospitals Status Sheet

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ATTACHMENT
11/23/94

MEDICARE COSTS VS. TEFRA LIMITS
LONG TERM HOSPITALS

Total Hospitals Reporting	75
Under Limits	19
Over Limits	40
No Limits	16
Average Length of Stay (Total)	28.46
Average Length of Stay (Under)	27.68
Average Length of Stay (Over)	28.60
Average Length of Stay (No Limit)	30.18
Average No. Medicare Days (Total)	7,538
Average No. Medicare Days (Under)	11,813
Average No. Medicare Days (Over)	6,270
Average No. Medicare Days (No Limit)	5,631
Average No. Medicare Discharges (Total)	265
Average No. Medicare Discharges (Under)	427
Average No. Medicare Discharges (Over)	219
Average No. Medicare Discharges (No Limit)	187
Average Cost Per Discharge (Total)	$15,877
Average Cost Per Discharge (Under)	$13,004
Average Cost Per Discharge (Over)	$16,050
Average Cost Per Discharge (No Limit)	$23,176
Average TEFRA Limit - All Discharges (Under)	$16,308
Average TEFRA Limit - All Discharges (Over)	$11,831
Average TEFRA Limit - per Hospital (Under)	$21,740
Average TEFRA Limit - per Hospital (Over)	$11,181
Average Cost Per Day (Total)	$558
Average Cost Per Day (Under)	$470
Average Cost Per Day (Over)	$561
Average Cost Per Day (No Limit)	$768
Average Medicare Cost Under Limits	$1,410,101
Average Medicare Cost Over Limits	$925,145
Total Medicare Cost Under Limits	$26,791,922
Total Medicare Cost Over Limts	$37,005,813
Total Incentive Payments (Under Limits)	$4,740,793
Total Cost Sharing (Over Limits)	$6,388,328

Data Source: PPS-IX Minimum Dataset
For fiscal periods beginning on or after 10/01/91 and ending by 8/31/93

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

SUBMITTED TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

FOR THE RECORD OF THE HEARING ON MEDICARE ISSUES
-FOCUS ON CONTROLLING COSTS AND IMPROVING CARE-
ISSUES RELATED TO MEDICARE MANAGED CARE ALTERNATIVES

FEBRUARY 10, 1995

Mr. Chairman:

This testimony is being submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on managed care and the Medicare system.

American Rehab is a national organization representing over 900 members who provide inpatient, outpatient, vocational and community based rehabilitation programs and services to over 4 million people annually.

All of us will probably need at least one rehabilitation service sometime in our life. As we go about our daily lives none of us contemplate if we will have a stroke, break a hip, hit our head, have a spinal cord injury, be shot or stabbed or have a child born with a congenital problem. We do not think about this as our future.. But for many Americans, unexpectedly and unfortunately these things happen. These types of illnesses or injuries require rehabilitation services to help return people to home, to work, to school and ideally to an active life. For a child born with a congenital or genetic disorder, rehabilitation services can help them walk, move, write, feed themselves, and therefor attend school, participate in social events and enjoy the kind of life that most of us think is what life is all about.

AGING OF AMERICANS

Demographic trends in the population at large suggest that the prevalence of disabling conditions will increase in the future as more individuals live longer. Table 1 shows the expected growth of the number of persons over 65 in the U.S. (see Attachment I) It can be seen that dramatic growth will occur between the years 2000 and 2025 when the aged population will nearly double. Table 2 shows the percentage of persons in each age group that have a functional limitation. (see Attachment I) From this table it can be seen that 58.5% of persons 65 years and older have a functional limitation. Thus, in the future, as more individuals live past 65 years of age, the U.S. will be faced with a larger population of persons with functional limitations, challenging the medical rehabilitation field to provide effective care and services.

Age of Rehabilitation Patients

Data presented in Table 3 provide estimates of the average age of patients admitted for inpatient rehabilitation by impairment condition. (see Attachment I)

The average age of patients admitted for stroke, orthopedic condition, non-traumatic spinal cord dysfunction, and neurologic condition are all greater than or equal to 60 years of age, which reinforces the impact that the "greying of America" will have on the utilization of rehabilitation services in the future. By contrast, lower average ages for traumatically impaired brain and spinal cord patients is indicative of the prevalence of injury, accident, and violent crime, and related medical impairments, for relatively young patients. The UDS_{MR} data suggest a general trend of an increase in the average age of rehabilitation patients (1990: 67 years; 1992; 69 years). Again, as the life span of Americans increases the demands for rehabilitation services will also increase.

BACKGROUND ON REHABILITATION

Rehabilitation services are an integral part of our American health care system. They are very cost effective. For example a Northwestern National Life study shows an average savings of $35 in disability reserves for every $1 spent on rehabilitation services to return injured workers to work.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person has had a stroke which impairs the ability to walk, see, swallow and creates weakness on the left side. The goals include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. Over 80% of the 4 million people receiving rehabilitation services return to their homes, work, schools or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, skilled nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

The rehabilitation field is responding to the changes in the health care field. It is becoming more cost effective through the use of critical pathways, decision rules and constant examination of the use of resources and outcomes. All of these practices help make decisions about the appropriate use of resources and help cut costs.

EFFECTIVENESS OF REHABILITATION

If rehabilitation services are delivered, they are most effective if delivered early after trauma or illness. For example, rehabilitation is one of the evaluations done right in the trauma center. If an appropriate referral is not made the person remains dependent, the family suffers and society, the individual and the family pay more than just financially. In a study of the cost benefits of stroke, the investigators found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus in a nursing home setting saved $13,248 per year in 1981 dollars, or $21,599.54 in 1994 dollars per year. Given that the average stroke patient lives over 5 years this is a savings of $107,997.70 in 1994 dollars.

An article in the 1994 October/November/December issue of TQM magazine, "Judging the Cost-Effectiveness of Rehabilitation", discussed the cost effectiveness of rehabilitation. Pulmonary rehabilitation improves patient function and reduces the use of medical services. Early rehabilitation in a rehabilitation unit for stroke patients is more effective than for patients treated on general medical wards. Twice as many of the patients who did not receive rehabilitation went to nursing homes and the mean time in an institution in the first year, including nursing homes was 75 days for the rehabilitation patients and 123 days for the patients who did not get the rehab program.

For traumatic brain injury (TBI) early initiation of rehabilitation can save costs. A recent study compared patients from one hospital with an aggressive early rehabilitation program for TBI with those from 11 other hospitals without organized programs. Patients from the formal program experienced one third the time in a coma. Also the rehabilitation length of stay averaged 54 days vs. 106 days for those coming from routine care. Ninety-four percent (94%) were discharged home in the early intervention program compared to 57% of the others. Again, there is an enormous amount of money saved simply by calculating the cost of days **not** spent in the hospital.

MEDICARE, REHABILITATION AND HMOs

As noted previously, the Medicare program impacts the medical rehabilitation industry significantly in accounting for over 60% of inpatient days, and the Medicare program has not been immune to the managed care movement. Medicare HMO volume in the form of Medicare risk contracts has grown since the 1980s. In 1993, there were nearly 1.7 million enrollees under Medicare risk contracts, which is more than three times greater that the 467,000 enrollees in 1986 (McMillan, 1993). However, as McMillan notes, through 1993 there has been moderate growth in Medicare HMOs. A recent study by the GAO predicted an increase of 20% in enrollment in risk contract HMOs in 1994. This is 2.3 million beneficiaries or 6.5% of total Medicare beneficiaries. Medicare HMO activity is also concentrated geographically in a few large plans. For example, California and Florida account for over one-third of Medicare HMO enrollees, and one-half of the states have no Medicare HMO enrollment.

Nonetheless, the result of the continued overall growth of managed care is that rehabilitation providers are and will continue to be compelled to accommodate to HMO-type plans and document the cost-effectiveness/cost-benefits of their services in response to case management and utilization review pressures. Managed care requires that health systems provide a vertically integrated continuum of care which allows patients to receive quality in the lowest cost environment. The rehabilitation industry will be compelled to meet this requirement in order to gain managed care contracts. Managed care has essentially altered the relationship between provider and insurer, and providers will assume more financial risk under a fixed payment system.

The managed care movement has also provided strong impetus for the development of outcomes-based health care, in which providers are asked to objectively document the clinical outcomes of care relative to expenditures. The ability of rehabilitation facilities to provide outcomes data is a crucial issue as patients, payors, and businesses are all becoming increasingly involved in outcome measurement. Rehabilitation hospitals and clinics will be held increasingly accountable by payors for effective rehabilitation programs. Payors often request information on functional assessment, cost data, and patient satisfaction. The future of rehabilitation programs appears to depend on whether or not the program can document the success of their treatment's outcomes.

Medical rehabilitation, relative to other health care professions and industries, has made significant progress in implementing systematic outcomes assessment systems. For example, several outcome assessment systems are currently being used by rehabilitation facilities to document outcomes. Examples of these systems include: Functional Independence measure managed by UDS_{MR}; Restore and Level of Rehabilitation Scale (LORS) managed by Formations in Healthcare; Patient Evaluation & Conference System (PECS) managed by Marianjoy Rehabilitation Hospital and Clinics; and Total Outcome Prediction Program (TOPP) managed by Continental Medical Systems, Inc.

ISSUES

As this committee looks for ways to bring Medicare into the next century, ensure its financial viability and examine current managed care practices as possible models for the Medicare program, we want to highlight several issues we have encountered. They are:

* coverage of rehabilitation services and providers;
* incentives, or not, to refer for specialty services;
* the quality of rehabilitation services provided.

I. Coverage

Medicare covers a broad range of health care services for its eligible beneficiaries and is the single largest payor of medical rehabilitation services in the United States accounting five years ago, for an average of 40% of revenues in rehabilitation hospitals and more than 50% in rehabilitation units (Langenbrunner, Willis, Jencks, Dobson, & Lezzoni, 1989). More current estimates indicate that Medicare "days" account for between 60-70% of total inpatient days in rehabilitation hospitals and units. It is estimated that in 1994, 37 million persons will be enrolled in Medicare - 32.8 million aged persons and 4.2 million disabled persons. For eligible beneficiaries, Medicare covers certain inpatient and outpatient rehabilitation services provided at a rehabilitation hospital or unit of an acute care hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), rehabilitation agency, therapist's office, or at a patient's home through the services of a home care agency.

Medicare Beneficiaries in HMOs

An American Rehab survey found that of those HMOs that referred enrollees to rehabilitation hospitals and units and limited the number of days, the average number of covered days was 58. Sixty nine percent (69%) of the rehabilitation hospitals and units to which HMOs referred Medicare patients reported that the HMO limits the numbers of days of therapy, with an average limit of 51 days. We find this information about Medicare beneficiaries particularly disconcerting because it is our understanding that the Medicare package of benefits is to be available to Medicare rehabilitation patients. Under Medicare there are no day limits on therapies or programs. Medical necessity is determined by the Medicare inpatient rehabilitation hospital guidelines.

Recommendations:

(1) There are rational coverage guidelines for inpatient rehabilitation hospital and unit services and outpatient services. To determine medical necessity of rehabilitation for Medicare beneficiaries they are based on the patient's need and progress, not an arbitrary limit. The current Medicare inpatient and outpatient guidelines should be used by HMOs while options are examined.

II. Incentives for Referrals

Managed care plans frequently place physicians at financial risk when they serve people who need intensive, on going services. This is particularly true for nonsalaried physicians who receive a capitated payment for each enrollee. Other plans attempt to pass on risk to providers in the form of financial incentives that lead to under service. These include bonuses or penalties to providers related to meeting, or exceeding, utilization limits and policies requiring physicians to assume the cost of out of plan specialty care. Other plans withhold a percentage of a providers' income if they exceed a targeted number of referrals to specialists and/or hospitalizations. These financial incentives coupled with any lack of awareness of the value of rehabilitation result in many people who need rehabilitation services and many people with disabilities not receiving needed care and remaining needlessly dependent at great cost to them and society. Or, they go out of plan and have to pay for the specialty care at great cost.

The American Rehab study found that 27% of the facilities that have contracts with HMOs for non Medicare enrollees said that the HMO does not refer enrollees to rehabilitation hospitals/ units. One-half of the facilities that have Medicare contracts reported that the HMO does not refer to rehabilitation hospitals/ units. Of those that do not refer Medicare enrollees, 57% said that the HMO states that it is not medically necessary; 25% said the HMO says care can be provided at a skilled nursing facility and 13% said that the HMO states that cost is the reason for not referring to rehabilitation hospitals and units.

Several studies raise concerns about HMO treatment of Medicare beneficiaries as well. The Medicare Advocacy Project, Los Angeles, California in its January 1993 report, "Medicare Risk-Contract HMOs in California: A Study of Marketing, Quality, and Due Process Rights" noted the following problems:

* Failure to refer for needed specialty care. The decision may not be made by the gatekeeper physician but by the medical group manager, utilization review coordinator or medical director. They also cited the physician financial incentive issues mentioned above.

* Not having enough contracting specialty physicians available or when the financial incentives delay referrals to specialty physicians.

* Failure to refer for rehabilitation. The frequency with which HMOs deny access to home health care and inpatient rehabilitation services... "raises questions about the financial incentives under which HMOs and their subcontracting provider groups operate." The report questions the HMOs determinations that cases that appear to meet the Medicare coverage guidelines were denied the care as not medically necessary.

Recommendations:

(1) Establish criteria for HMO Medicare plans to assure that an individual a) with one of the conditions usually requiring rehabilitation services, b) with a congenital disability, and/or c) with a specific functional status based on a functional assessment, receive a rehabilitation evaluation within 72 hours upon seeing a primary care provider or other gatekeeper. The conditions in question include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

(2) Assure that physician referrals to physician and non-physician specialists are based solely on the needs of the patient. Financial incentives for referrals and/or for denying referrals should be prohibited.

(3) Assure that persons requiring rehabilitation services and persons with disabilities in particular can select a primary care provider or gatekeeper who is a physiatrist, an otherwise qualified rehabilitation physician or a specialist in the medical management of their particular condition.

(4) Assure that rehabilitation services are provided for as long as a patient is making progress and achieving rehabilitation goals.

III. Quality Concerns

We are also concerned about the quality of care given to many HMO Medicare enrollees. This is a difficult issue to quantify. As noted, above we have heard about problems with people either not being referred at all for rehabilitation or being referred but with a limit on the number of days. Quality goes to the setting to which the patient is referred for services and the duration, frequency and type of treatment they receive. Our members have told us about enrollees, both Medicare and non-Medicare, being sent to what we characterize as a custodial institutional setting that provides either no or periodic skilled nursing and rehabilitation therapies as required under OBRA '90, but not a comprehensive rehabilitation program. Our members do not believe many of these patients obtain their maximum outcomes and the rates of return to home, work, school and an active retirement are not as high as possible. This is a tragic personal, professional, familial, social and financial loss and burden.

The Medicare Advocacy Project Report cited above noted several cases where the HMOs approved less care than needed. The report states the "survey also points to possible systemic bias by some HMOs against referrals for in-patient rehabilitation services. All five of the southern California in-patient rehabilitation hospitals responding to MAP's survey felt that some Medicare HMOs denied medically necessary rehabilitation services to a greater extent than occurred in FFS [fee for service]. " The report further states "some HMOs appear to use arbitrary standards to deny or discontinue rehabilitation care." These standards include the patient's age even when a patient was improving.

The Mathematica study released in December, 1993 also raised concerns about quality of care. Mathematica looked at rates of death, hospital readmission and post admission complications as gross outcomes" measures but did not make any adverse findings. However it did state," ...a few differences do indicate that HMOs may be providing less adequate care in some situations. ...HMO stroke patients received significantly less physical therapy while in the hospital and had greater motor and speech deficits at discharge, yet were not more likely to have a post discharge speech or physical therapy plan. This pattern suggests that HMOs may economize on rehabilitation care...Although there is no evidence that these differences in care led to poorer patient outcomes, they cause some concern because of their potential adverse effect on outcomes."

The study noted that HMOs discharge a higher proportion of stroke patients to nursing homes and a lower proportion to rehabilitation hospitals. While it did not have follow up data, this practice raised concerns about whether this pattern was leading to poorer care.

Outcomes as a measure of quality are well accepted in the rehabilitation field because of its focus on the functional status of the patient. Rehabilitation concentrates on the changes in function which occur during the course of treatment, as revealed by comparing patient status at the time of admission to the time of discharge. The continuation of these gains is monitored through follow up functional assessment after discharge. Several functional assessment measures in the rehabilitation field have been developed and may be adapted to measuring outcomes. The majority were developed for use in inpatient services. One is being adapted so that it can be used in a skilled nursing setting as well as an hospital inpatient setting. A patient classification system has also been developed for rehabilitation by American Rehab and the University of Pennsylvania. It is based on functional status at admission, age and impairment category. It uses 55 functionally related groups (FRG's) which classify patients and predicts length of stay. With future research it may be adapted to predict outcomes as well.

However as these predictive tools are being developed and implemented we remain concerned that both Medicare and non Medicare enrollees continue to be sent to less intense rehabilitation service settings where they achieve less than maximum outcomes. They simply are not being allowed to function at the level at which they are able with appropriate therapies.

Recommendations:

1. HCFA should direct Medicare HMOs that they cannot use arbitrary rules of thumb to deny rehabilitation care to Medicare beneficiaries, e.g. age or deny any Medicare benefits to beneficiaries. If an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines he or she should be referred for those services.

2. HCFA should increase its review of Medicare risk contractors' practices in referring patients who require rehabilitation to less intense levels of services which may result in decreased positive functional outcomes.

3. Quality criteria by which to determine HMO approval of rehabilitation services to Medicare beneficiaries should include patient outcomes including, but not limited to, death, pressure sores, discharge status, and change in functional motor and cognitive function, and others.

We would be pleased to discuss these critical issues with you Mr. Chairman

ATTACHMENT I

Table 1. Projected Growth of the Number of Persons 65 Years and Older in the U.S.: 1995-2075

Aged Population /Projected	1995	2000	2025 (in millions)	2050	2075
65 years and older	34.0	35.2	60.6	73.7	83.3
75 years and older	15.0	16.7	25.0	38.9	45.7
85 years and older	3.8	4.4	6.3	14.6	16.9

Source: HCFA Statistics, Baltimore, MD

Table 2. Percentage of Persons by Age Group that Have a Functional Limitation

Age	Total (in 1,000s)	Percent With a Functional Limitation	Percent With A Severe Functional Limitation
15-24 years	39,297	5.2	0.9
25-34 years	40,464	7.5	1.5
35-44 years	30,480	13.4	2.9
45-54 years	22,264	23.0	6.4
55-64 years	22,060	34.2	12.4
65 years & over	26,422	58.5	28.5
65-69 years	8,928	45.4	18.8
70-74 years	7,378	55.3	22.9
≥ 75 years	10,116	72.5	41.2

Source: U.S. Bureau of the Census, 1984 Survey of Income and Program Participation, Current Populations Report, Series P-70, No. 8, Table C.

Table 3. Average Age of Patients Admitted for Inpatient Rehabilitation by Condition: 1990-1992

	1990	1991	1992
Condition	Avg. Age (in years)	Avg. Age (in years)	Avg. Age (in years)
Stroke	70	71	71
Orthopedic Conditions	74	75	75
Brain Dysfunction-Nontraumatic	58	60	59
Brain Dysfunction-Traumatic	38	39	40
Spinal Cord Dysfunction-Nontraumatic	64	63	64
Spinal Cord Dysfunction-Traumatic	43	40	42
Neurologic Conditions	60	60	62
All Patients	67 (N=33,427 patients)	68 (N=44,997 patients)	69 (N=83,571 patients)

Source:(data from UDS$_{MR}$); American Journal of Physical Medicine & Rehabilitation, vol 73, no. 1, February 1994, 51-55.

THE ASSOCIATED GROUP

120 Monument Circle
Indianapolis, IN 46204-4903
317-488-6337 . FAX 317-488-6306

SUSAN J. SMITH
Vice President
Government Relations

SUBMITTED STATEMENT OF
SUSAN J. SMITH
VICE PRESIDENT OF GOVERNMENT RELATIONS
THE ASSOCIATED GROUP
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

IN SUPPORT OF H.R. 483,
THE MEDICARE SELECT EXPANSION ACT OF 1995

FEBRUARY 10, 1995

Mr. Chairman and members of the Subcommittee, The Associated Group appreciates this opportunity to discuss its support of H.R. 483, a bill to amend Title XVIII of the Social Security Act to permit Medicare Select policies to be offered in all States. This bill was introduced on January 11, 1995 and earlier this week had a bipartisan group of 77 cosponsors who we are pleased to note include you Mr. Chairman and Chairman Bill Archer.

The Associated Group is a national diversified insurance and financial services company doing business in 49 states, based in Indianapolis, Indiana. As a $3.4 billion (revenues) company, The Associated Group offers a variety of products, including:

- health, life, and property and casualty insurance;
- managed care and integrated delivery networks;
- asset management, equipment leasing, and receivables management; and
- market research.

The Associated Group is a for-profit mutual insurance company and the Blue Cross Blue Shield licensee in Indiana and Kentucky. In 1993, The Associated Group merged with Southeastern Mutual Insurance Company in Louisville, Kentucky (then the licensee for Blue Cross Blue Shield products in Kentucky). The Associated Group now employs more than 13,000 people with major concentrations in Indiana, Kentucky, Ohio, West Virginia, Florida, Texas and California.

The Associated Group supports the use of managed care as a tool to reduce the cost of health care in the United States. We believe that the development of high quality managed care networks for seniors is a critical part of our efforts to lower the cost of health care while offering our enrollees the highest quality of care. The Associated Group recruits network providers that have expertise in responding to the health care needs of seniors. This ensures that our enrollees are receiving the best possible care.

The Associated Group supports H.R. 483, introduced by Representative Nancy Johnson, a member of this Subcommittee. Over 400,000 Medicare beneficiaries are currently enrolled in Medicare Select. H.R. 483 will make this program permanent and available in all fifty states. We also take this opportunity to thank Representative Pete Stark and Representative Johnson for their bipartisan efforts at the end of the 103rd Congress to secure enactment of H.R. 5252, which extended the Medicare Select program until June 1995.

The Associated Group currently has over 14,500 enrollees in the Medicare Select program in Kentucky and Indiana. The Associated Group is developing additional Medicare Select networks in Texas and Indiana. Moreover, our current Indiana and Kentucky Medicare Select networks continue to attract new enrollees. Our Medicare Select enrollees enjoy an average premium savings of 27 percent from traditional fee-for-service Medigap insurance offered by our company. For individuals on fixed incomes, this represents very real, tangible savings. We believe that it is important that consumers continue to have this lower cost managed care option available.

We realize there is an ongoing dialogue about improving this program, and The Associated Group will continue to participate in these discussions. However, H.R. 483 needs to be enacted by this April to avoid any disruption in the program. If this program ends in June 1995, hundreds of thousands of seniors will be forced to pay higher premiums for Medigap insurance. In addition, managed care networks specifically developed to provide quality care to seniors at a lower cost will dissolve, limiting access to managed care for this segment of the population.

Critics of the Medicare Select program have raised questions about consumer protection provisions. Federal and NAIC standards for Medigap and Medicare Select require the Select products to provide the same consumer protections that are required of Medicare At-Risk HMO offerings.

Before enrolling in our Medicare Select program, an applicant receives the following information about our program:

- an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy with traditional Medigap policies and other Medicare Select policies;
- a description including address, phone number and hours of operation of network providers;
- a description of the network restrictions, including payments for coinsurance and deductibles when providers other than network providers are utilized;
- a description of coverage for emergency and urgently needed care and other out-of-service area coverage;
- a description of limitations on referrals to restricted network providers and to other providers;
- a description of the policyholder's rights to purchase any other traditional Medigap policy offered by our company; and
- a description of our quality assurance program and grievance procedures.

These consumer protections are designed to ensure that the consumer has knowledge of and fully understands the program in which he is enrolling including any restrictions or limitations on providers or coverages. State departments of insurance review and approve the descriptions noted above prior to their use. The regulation of these consumer protections as well as those placed on traditional Medigap insurance is done by state departments of insurance at no cost to the federal government.

Under the Medicare Select program, Medicare beneficiaries have the option to purchase lower cost supplemental insurance through managed care networks. The Associated Group urges Congress to make this program permanent and available to seniors in all fifty states. Mr. Chairman and Members of the Subcommittee, The Associated Group urges your support of H.R. 483.

Statement of the College of American Pathologists for the record of the House Ways and Means Subcommittee on Health hearing regarding "Extraordinary Growth in Certain Medicare Costs," February 6, 1995

The College of American Pathologists (CAP) appreciates the opportunity to present its views to the Ways and Means Subcommittee on Health regarding growth in certain areas of Medicare costs. The College is a national medical society representing more than 14,800 physicians who are board certified in clinical and/or anatomic pathology. College members practice their specialty in community hospitals, independent clinical laboratories, academic medical centers, and federal and state health facilities.

Pathologists are responsible for the overall operation and administration of the laboratory and for ensuring that quality laboratory services are available. The College believes that pathologists must be involved in the determination of coverage and utilization of clinical and anatomic pathology services. Adequate resources must be allocated for the provision of laboratory direction, quality assurance, and other services provided by pathologists.

The College is grateful to the Subcommittee chair, Mr. Thomas, and the chair of the full Committee, Mr. Archer, for their leadership and foresight in holding hearings at an early date to examine the causes of unusual growth in Medicare costs and to consider how the program can be made more cost-efficient. Ideally, Medicare should be a model of efficient interaction between the public and private sectors in serving patients. While it has succeeded in improving the health of the elderly and disabled, the program is failing from a budgetary standpoint due to a flawed financial structure and unrealistic budget projections. Rather than deal with these underlying structural problems, Congress and the Executive Branch have historically attempted to deal with the program's financial problems by cutting provider payments and making numerous operational changes that have increased the burden and confusion for everyone involved with the program. The result has been cost-shifting to the private insurance market, where premiums and prices have increased dramatically. Now, as private payers intensify their bargaining with providers, the ability to cross-subsidize Medicare with private dollars is shrinking.

With the passage of the balanced budget constitutional amendment, the College is concerned that Congress will once again be under pressure to resort to short-sighted budget cuts to meet deficit reduction targets rather than taking a careful, comprehensive look at how the Medicare program could be financed more equitably. Medicare physician and laboratory payments cannot continue to be driven lower and lower in comparison to private market levels without soon affecting the availability and quality of medical services.

Physicians and laboratories have already sustained disproportionately deep reductions in Medicare payments during the past 13 years (see attached chart). Physicians, who account for 23 percent of Medicare outlays, have borne 32 percent of the Medicare provider cuts over the last decade. Of the $98 billion in Medicare cuts from 1981 to 1993, payment cuts to physicians accounted for $39 billion. Laboratory services, which account for less that eight percent of Medicare Part B expenditures, sustained $6.8 billion in Medicare payment cuts between 1984 and 1993.

Clinical laboratory payments have been a consistent target for cuts over the last eight years and are currently in the midst of a three-year phased-in 12 percent reduction in the national limitation amounts approved as part of the 1993 Omnibus Budget Reconciliation Act. That measure also included elimination of the CPI update for laboratories in 1994 and 1995, for a total five-year cut in laboratory payments of $3.3 billion.

While the College is pleased that the President's budget proposal for fiscal year 1996 does not include any additional reduction in Medicare payments to physicians and laboratories, we are concerned that Congress, in its effort to achieve greater deficit reduction, will once again turn to Medicare providers for significant savings.

We would like to take this opportunity to comment on several policies proposed during the 103rd Congress that we believe may be considered again this year in the context of deficit reduction.

Competitive Bidding for Clinical Laboratory Services

The ill-conceived idea of instituting a competitive bidding process for Medicare clinical laboratory services was considered last year, despite the fact that Congress has repeatedly rejected it. The College was pleased that the Ways and Means Committee did not include this proposal in the comprehensive health reform legislation it adopted last year.

Competitive bidding contracts, particularly exclusive "winner-take-all" contracts, have proven to be unworkable because they create a strong incentive for laboratories to submit "low-ball" bids to become the exclusive supplier. These bids can result in below-cost contract prices which ultimately prevent the laboratory from having the resources necessary to assure high quality testing. For example, the Air Force selected a laboratory to screen Pap smears under such a process and found that the laboratory performed so poorly that women's lives were placed at risk. The Air Force had to impound more than 700,000 Pap smear specimens for retesting.

Access to the full range of laboratory services in rural areas could be adversely affected by a competitive bidding process, even if rural areas are exempted from the process. Because of the severe cost constraints imposed on the winning bidder under competitive bidding, laboratories might no longer be able to provide daily courier pick-ups, 24-hour turnaround for test results, and other services.

While competitive bidding is poor policy for all clinical laboratory services, it is particularly inappropriate for surgical pathology and cytology services. These services require the involvement of highly trained physician specialists with the personal knowledge of and accessability to the referring physician in making the appropriate diagnosis. Laboratory testing is a service, not a product or a commodity. Physicians choose one laboratory over another in part because of the mix of quality and service attributes of their selected facility. A competitive bidding process would ignore these other equally important factors and would prevent the physician from playing any role in selecting the best laboratory for his or her patient's needs.

Medicare Relative Value Scale Policies

The current Medicare Relative Value Scale (RVS) payment system for physicians is the result of lengthy, complex deliberations. Enacted in 1989, it is just beginning the fourth year of its five-year implementation. The College strongly believes that Congress should exercise great caution in considering any changes to the Medicare RVS system.

Medicare RVS fee schedule amounts are already too low in many instances. Continued erosion of the Medicare RVS payments and changes in methodology could exacerbate this problem and ultimately lead to reductions in quality of medical care. A recent CBO analysis of Medicare cuts stated that "growing disparities in rates between Medicare and the private sector that would result from these cuts could impair access of Medicare beneficiaries to health care." In 1994, on average, Medicare paid only 59 percent of the amount paid by private insurers. Under current law, Medicare payments are projected to fall to 56 percent of private insurance payments by the year 2000. Practice overhead costs are generally rising much faster than annual Medicare updates. Additional cuts will result in cost-shifting to private payers, forcing businesses and employers to face higher costs.

In particular, the College is concerned about several proposals consider by the previous Congress:

- Changing the Medicare Volume Performance Standard. The Medicare Volume Performance Standard is an integral component of the Medicare RVS update methodology and should not be manipulated to produce overall budget savings. If the MVPS is to be meaningful it must be based on changes in expenditures for Medicare services not on changes in the general economy and should not be so changed that inflation updates in subsequent years are unrealistic.

Use of a cumulative MVPS, tying Medicare spending updates to growth in the overall economy rather than in the Medicare sector, and other proposed changes in the MVPS methodology would likely result in establishing MVPSs that would be so low that physicians would not be able to meet them, leading to arbitrary and real cuts in payments. Further, the changes would result in lower conversion factor updates that would cause further reductions in payments in the future.

- Reducing Medicare relative values for non-primary care services. The College appreciates the need to ensure an adequate supply of primary care physicians. However, reductions in non-primary care services relative values or development of "outlier intensity" relative value adjustments to increase payment for primary care services undermine the resource-based methodology on which the RVS is predicated. Congress should not consider arbitrary adjustments proposed outside the formal RVS update and refinement process.

- Reducing payment to so-called "high-cost" hospital medical staff. The College opposes efforts to create another layer of Medicare Volume Performance Standards at the individual hospital staff level — the proposed reduction in payments for so-called "high-cost" medical staffs. If adopted and implemented, this policy would be divisive to hospital medical staffs, administratively complex, difficult to implement and maintain, ineffective in cost containment, and could threaten the delivery of quality health care. It is inappropriate to punish an entire medical staff for so-called excess relative values generated perhaps by only a portion of the medical staff. Further, the policy would distort the relationship of relative values among services and undermine the reasonableness of the Medicare RVS.

- Establishing "Centers of Excellence" contracting. Congress should use extreme caution in considering the concept of so-called "Centers of Excellence" contracting, where an all-inclusive rate, including the physicians' professional services, is paid by the Medicare program to the facility in which a surgical procedure is provided. It is essential that a requirement for payment to the *physician* for services provided be a part of the contracting process. Payment to a hospital or other facility for physician services does not ensure the facility will appropriately compensate the physicians for their services. Further, while "Centers of Excellence" naturally develop, it is important that aggressive contracting not stifle competition and decrease access to care through over-centralization.

Coinsurance for Medicare Laboratory Services

While the College understands and generally agrees with the need to make Medicare beneficiaries more aware of the cost of the medical care they receive, we urge Congress to reject the idea of reimposing a 20 percent coinsurance payment for Medicare clinical laboratory services, as it did during consideration of comprehensive health reform legislation last year. Since eliminating the coinsurance requirement for these services in 1984 Congress has repeatedly rejected proposals to restore it, with good reason. Reimposing coinsurance would place a significant administrative burden on laboratories and a new cost on beneficiaries while doing little to affect utilization of laboratory services; in many instances the cost of billing for coinsurance will exceed the amount collected from the beneficiary.

If coinsurance were reimposed, laboratories presumably would have to produce two claims — one to the Medicare Program and one to the patient. On average, laboratories estimate it would cost between $3 and $5 just to produce the additional invoice covering the coinsurance. In many instances, this cost would be a substantial percentage of the amount collected from the patient and could easily exceed collected amounts. The table below illustrates the approximate coinsurance amount for several commonly ordered tests once the OBRA '93 reductions are fully phased in. For these common tests, the collection costs exceed the coinsurance payments:

	Cap	Coinsurance
Multichannel Chemistry Test	$14.86	$2.98
CBC, with differential	$10.36	$2.02
Urinalysis	$ 4.24	$0.85

Past experience with coinsurance suggests that many laboratories will have to write off from 20 to 50 percent of the billed amounts as uncollectible. These collection problems are the very reason that coinsurance was eliminated by Congress as part of DEFRA '84, with the support of the Health Care Financing Administration and the laboratory industry. In exchange for eliminating the copayment, Congress mandated the current fee schedule methodology, which set the fee schedules at 60 percent of then-prevailing charges.

Imposition of coinsurance would shift the costs of the Medicare program to beneficiaries and force them to incur an additional $7 billion in out-of-pocket expenses, a burden that Congress specifically relieved them of in 1984. However, it is unlikely that coinsurance would have any impact on the volume of clinical laboratory services performed. Patients do not decide when to order testing nor do they select the testing laboratory. These decisions are made by the physician. Thus, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization. As the Congressional Budget Office noted in a 1990 Report, "Cost-sharing probably would not affect enrollees' use of laboratory services substantially...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing."

Medical Liability Reform

The College appreciates the strong support that many members of this Subcommittee have shown for federal legislation to reform the current medical liability system. As members are well aware, the cost of the current liability system is unacceptable. The American Medical Association estimates that more than $9 billion will be paid in premiums this year by physicians and hospitals for medical malpractice insurance. In addition, conservative estimates of the cost of "defensive medicine," tests and procedures performed solely to avoid suit, will be between $4 billion and $25 billion this year.

We believe the evidence is clear that comprehensive medical liability reform can be effective in reducing costs and assuring access to the liability system. Twenty years ago, insurance premiums in California were among the highest in the nation. State legislators adopted the Medical Injury Compensation Reform Act, known as MICRA, in 1975. Today, California's insurance premiums are below average for all states and one-half to one-third of those in high population states that have not adopted MICRA reforms. The difference has been the reduction in windfall awards and excessive legal fees.

The College strongly supports enactment of medical liability reform to promote the basic goal of providing access to all necessary health services, deter substandard or unethical practices and encourage improvements in the safety and quality of medical care. Based on California's MICRA, these reforms should include:

- a $250,000 limit on the total amount of non-economic damages;
- binding mandatory alternative dispute resolution systems administered by the state to resolve medical liability claims;
- reduction of the total amount of damages by the amount of payments from collateral sources;
- mandatory periodic payment of awards;
- a sliding scale limit on attorneys contingency fees; and
- the use of practice guidelines developed by professional associations as an affirmative defense in liability actions.

Graduate Medical Education

While the College recognizes the appropriateness of increasing the nation's supply of primary care physicians under a reformed health care delivery system, several proposals under recent consideration raise serious concerns. Of greatest concern are proposals that would authorize the federal government to restrict the number and types of medical residencies. The College believes that the extent of federal involvement in medical residency training should be limited and opposes federal restrictions on the numbers and specialty mix of medical residencies. Residency choices of medical students are based on a complex set of variables. Federally imposed restrictions or distortion in the Medicare Relative Value Scale (RVS) to provide incentives to enter primary care residencies are ill-concieved and inappropriate. We believe that the objective of achieving an appropriate balance of primary care and specialty residency positions can be better achieved in other ways.

Any changes in funding for graduate medical education must ensure that an adequate supply of specialists is trained to meet the nation's during the upcoming century. Pathologists are uniquely trained to provide a range of medical services that are critical to the prevention, detection, and treatment of disease. These services will be equally important to providing high-quality health care under any reformed delivery system. Through attrition, pathology is losing an average of 1.87 pathologists per day with only .96 newly trained pathologists per day entering the specialty. Any changes in funding for graduate medical education must ensure that an adequate supply of pathologists is trained to meet future health care needs.

Direct Billing for Clinical Laboratory Services

In order to provide clinical laboratory services as efficiently and cost effectively as possible, the College urges Congress to require that laboratories seek payment directly from the patient or a financially responsible third party, such as the patient's insurer. Medicare already requires laboratories to bill the program directly for clinical diagnostic laboratory testing provided to its beneficiaries. In addition, California, New York and Rhode Island have each enacted some form of direct billing. Payors in other jurisdictions, such as Michigan, Connecticut and Pennsylvania, require direct billing as a matter of payment policy. A national direct billing requirement was included in virtually every major health reform proposal considered by Congress last year.

The Center for Health Policy Studies (CHPS) recently completed an analysis that found that the number of services per person is *28 percent greater in non-direct billing states* than in states where direct billing is required and that *total lab charges per person are 41 percent higher* in non-direct billing states. CHPS concluded that if a direct billing requirement were adopted nationwide, *the annual private sector cost savings* attributable to this change would fall in the range of *$2.4 to $3.2 billion*, or *between $12 billion and $16 billion over five years.*

In addition, CHPS suggested that Medicare expenditures could also be reduced by enactment of a national direct billing requirement, even though such a policy already exists for Medicare. CHPS found that Medicare utilization declined in states that required direct billing, indicating that physicians changed their pattern of ordering clinical laboratory services for both Medicare and non-Medicare patients when direct billing was required.

Due Process Protection in Managed Care Plans

As the Subcommittee is well aware, competition for patients in the private marketplace is increasing dramatically. The College believes that appropriate safeguards must be established to respond to these changes. Patients and providers alike are concerned about denials of necessary services and restrictions in choice of physicians and other health professionals and facilities that are becoming more and more common as large insurers exercise greater control over medical treatment decisions. We are concerned about health plans that discriminate against people with health conditions that require expensive care by dropping their caregivers from health plan networks.

The College supports enactment of federal legislation to control these abusive practices through the same reasonable methods commonly used by high quality insurance plans. These include establishing standards of operation, full disclosure of those standards to patients and providers, and effective options for recourse when problems arise. These protections were introduced last year as the Patient Protection Act of 1994, and we encourage the Subcommittee to include similar provisions in legislation this year.

Specifically, Congress should enact protections to require that consumers receive easily understood information about covered and excluded procedures and requirement for prior authorization, to assure that plans do not deny access to physicians and providers unreasonably because of utilization review practices. Standards should be required for the hiring and firing of physicians and other providers, and the right of timely notice and appeals when previously-accepted contracts are adversely modified. Certification processes for managed care plans and utilization review programs that include periodic review and the opportunity to remedy deficiencies.

In conclusion, the College of American Pathologists appreciates the difficult task that the Subcommittee must confront. The necessity of addressing the long-term cost growth in the Medicare program means that hard choices must be made. We hope that you will resist the temptation to simply cut Medicare payments to health care providers and address the serious problems with the program's underlying financial structure. As you consider specific proposals this year, the College hopes that you will look on pathologists as an information resource on how patients will be affected. We look forward to working with you to achieve reasonable Medicare payment policies.

SUMMARY OF MAJOR REDUCTIONS IN PAYMENT FOR PATHOLOGY AND LABORATORY SERVICES

DEFRA '84

- Established Medicare Clinical Laboratory Fee Schedule (CLFS) at 60-62 percent of the then-prevailing charges
- Eliminated 20 percent coinsurance for Medicare clinical laboratory services

COBRA '86

- Established Medicare laboratory fee caps at 115 percent of the fee schedule medians

OBRA '87

- Reduced Medicare laboratory fee caps to 100 percent and limited the CPI update
- Reduced Medicare payment for certain automated tests by 8.3 percent

OBRA '89

- Reduced Medicare laboratory fee caps to 93 percent
- Established Medicare Resource Based Relative Value Scale (RVS) for physician services, reducing pathology services 23 percent from 1992 — 1996

OBRA '90

- Reduced Medicare laboratory fee caps to 88 percent and limited the CPI update
- Reduced Medicare payment for physician pathology services by 7 percent for 1991

OBRA '93

- Reduced Medicare laboratory fee caps to 76 percent over three years
- Eliminated Medicare laboratory fee schedule CPI update for 1994 and 1995
- Reduced Medicare RVS update for pathology and other non-surgical, non-primary care services by 2.6 percent for 1994 and 2.7 percent for 1995

College of American Pathologists

STATEMENT OF JAMES R. PATTON
EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER
THE WELLNESS PLAN
COMPREHENSIVE HEALTH SERVICES OF DETROIT

Background

Comprehensive Health Services of Detroit, known as The Wellness Plan (TWP), is a 501(c)(3) federally qualified health maintenance organization ("HMO") operating since 1972 and serving the Detroit metropolitan area. Currently, TWP has over 100,000 enrollees, approximately 90 percent of whom are enrolled through the state of Michigan Medicaid program. TWP is a well established HMO that has been recognized as a model quality Medicaid managed care program by such national leaders as Dr. Otis Bowen, former secretary of the Department of Health and Human Services. Although it has over 200 commercial accounts with medium and small businesses, enrolls nearly 10 percent of the federal employee health benefit plan participants in Detroit, and has accounts with major companies, TWP has a disproportionate percentage of Medicaid members from sectors of the city of Detroit the greatest preponderance of minority and low income populations. Based on its stellar performance, TWP is as qualified as any other HMO in serving Medicare patients. Indeed, despite the fact that it often serves the sickest and most vulnerable population in the city of Detroit, including many dual eligible persons (with Medicare and Medicaid coverage), its costs to the Medicare program are far below the average adjusted per capita cost rates paid to Medicare Risk Contractors.

In 1989, TWP applied to HCFA for a Medicare health care prepayment plan (HCPP) contract. While TWP would have preferred to have a contract authorized by section 1876 of the Social Security Act (a Cost or Risk Contract), it was and remains ineligible to participate in these contracts because of the enrollment composition rule. This rule requires that in order for a federally qualified HMO to be eligible at least 50 percent of its members must have coverage other than through Medicare or Medicaid. 42 U.S.C. § 1395mm(f)(1) and (2).

Technical Corrections Act of 1994

At the end of the last session, Congress enacted a bill known as the Social Security and Technical Corrections Act of 1994, H.R. 5252 (dated October 7, 1994). Section 171(f) would subject an HCPP contractor to Medigap laws and regulations as of January 1, 1996. (The full text of this provision is included as Appendix A.) Because these provisions are inherently contrary to the operations of HCPPs, Section 171(f) would make it impossible for an HCPP contractor to offer a "gap policy" to any of its individually enrolled Medicare members. This is critical because, without a gap policy Medicare beneficiaries would have no reason to enroll or remain enrolled in an HCPP contractor. Rather, HCPPs would have to limit offers of gap policies to persons enrolled in a group contract (e.g. Medicaid dually enrolled Medicare beneficiaries, retirees of union trust plans and employer group retiree plans), who do not fall under the scope of Section 171(f).

Historically, HCPP contractors generally, and all federally qualified HMOs, were exempt from the federal Medigap laws. HCFA apparently interprets Section 171(f) as restricting an HCPP contractor from offering a gap policy unless it is in conformance with requirements for a Medicare Supplement Policy ("Medigap policy"). Because Medigap policies are indemnity policies and because most federally qualified HMOs and most other state licensed HMOs are not licensed insurers, it is impossible for them to offer such policies solely through an HCPP.

Moreover, under federal law, a Medigap policy must reimburse benefits regardless of which provider or physician offers the care. In a few states, Congress provided an exception to the Medigap requirements enabling insurers and Blue Cross Blue Shield plans to offer Medicare Select, a Medicare PPO product. Even though Medicare Select allows for differences in reimbursement between in-network and out-of-network providers, it does not address most of the conflicts for HCPPs attempting to comply with Section 171(f). Specifically, by requiring an HCPP contractor to conform to Medicare Select, Section 171(f) would preclude an HCPP from offering its own unique version of covered benefits and require instead that the HCPP gap policy conform to 1 of 10 standard Medigap policies. None of these policies permit an HCPP contractor to use modest copayments (i.e., $5 to $10 for office visits and $25 to $50 for use of a hospital emergency room) to help manage usage of services by Medicare enrolled members of the HCPP. Nor does Medicare Select allow an HCPP to offer more comprehensive or more generous benefits, including extensive preventative care services that are not covered by Medicare or by Medigap policies.

Moreover, even for provisions that do not directly conflict with the obligations of an HCPP contractor, some requirements of Medicare Select, if implemented, could increase dramatically the administrative costs of operating an HCPP program. For example, even though the HCPP is paid its costs in lieu of the billed fees from a Medicare carrier, Section 171(f) would require an HCPP to submit bills to a Medicare carrier. Accordingly, the framework created by Section 171(f) is contrary to the framework of operating as an HCPP. (For additional details on the differences between Medicare Select and HCPP or HMO requirements see Appendix B.)

Comparison of HCPPs to Medicare Cost Contractors

In contrast with Section 171(f), Medicare Cost and Risk Contractors would continue to be exempt from Medigap requirements. All but a few Cost Contractors operate in exactly the same manner as TWP operates an HCPP. Indeed, HCPP contractors are held to the same standards as Cost Contractors for virtually all major financial and management aspects of their plans:

- Coverage -- Both must comply with Medicare coverage and reimbursement regulations and guidelines for non-provider services;
- Reimbursement -- Both are reimbursed on the basis of reasonable and allowable costs;
- Accountability -- Both must meet Medicare record keeping and reporting standards;
- Lock-in -- Both allow the Medicare enrolled member to elect out of plan services from Medicare on a fee-for-service basis, in the same fashion as a point of service plan or preferred provider organization, so that the patient never loses Medicare benefits;
- Marketing -- Both must comply with HCFA approval for marketing benefits;
- Quality of Care/Network Providers -- Both must utilize only Medicare approved health care practitioners;
- Quality Assurance -- Both must maintain adequate systems of quality assurance;
- Financial Risk -- Both have the same financial risk and flexibility to offer a gap policy to cover Medicare deductibles, copayments, and non-Medicare benefits and to charge no more than the actuarial value of Medicare deductibles and coinsurance.

There are only relatively minor differences between an HCPP and a Cost Contractor:

- Payment And Coverage Of Part A Provider Services -- while only Cost Contractors have the option of paying for these services directly, more than 90 percent of current Cost Contractors elect to have the Medicare fiscal intermediary pay providers directly. TWP arranges for such care with its network hospitals (through the Detroit Medical Center) and pays Medicare deductibles and copayments, in the same manner as Cost Contractors.

- Health Screening -- HCPPs are permitted to health screen while Cost Contractors are prohibited from health screening. In practice this is not followed by TWP or other HCPPs of which we are aware.

- Grievance And Appeals -- No specific regulation governs grievances and appeals within an HCPP, but TWP follows the same grievance and appeals procedures as a Cost Contractor. Other HCPP contractors that are licensed HMOs must follow at least the applicable state grievance and appeals process.

Impact and Recommendations

It is ironic that Congress, by adopting Section 171(f), could undermine the HCPP program when it has been a source of long term stable participation of HMOs with Medicare. Unlike the HMO Risk Program, HCPPs have not been criticized for having financial incentives to favorably select only healthy patients. Yet, HCPPs have served as an important feeder program that enables HMOs to shift to Risk Contracts once they gain experience in managing Medicare population. Few HCPPs have dropped out of the Medicare program and since the inception of the Risk Contract program 14 of the largest and most successful Risk Contractors were previously HCPPs. By contrast, in the first eight years of the Risk Contract program approximately 300 out of 400 contracts (or 75 percent) were terminated or non-renewed. **Accordingly, Congress should repeal Section 171(f) of the Social Security and Technical Corrections Amendments of 1994, otherwise it will be practically impossible for HCPP contractors such as TWP to continue to serve Medicare patients.**

Additional Recommendations

TWP believes that managed care can offer a more efficient and effective means of serving Medicare beneficiaries than traditional Medicare. Because of the wide variety of circumstances and obstacles affecting the availability of managed care plans for Medicare beneficiaries, Congress should approach the issue of Medicare managed care options by encouraging the offering of a variety of programs. Competition among plans will eventually force HMOs to whatever the Medicare beneficiaries seek in a plan. It is obvious, however, that no single type of managed care plan dominates throughout the country. In addition to repealing Section 171(f), TWP urges Congress to adopt changes to the Medicare managed care program and eliminate barriers to new managed care plans and to those plans that have specialized in serving the Medicaid population. Accodingly, Congress should consider the following recommendations:

> **Congress should amend 42 U.S.C. §1395()()() to allow a federally qualified HMO that is in full compliance with federal HMO Act requirements to obtain a waiver of the 50 percent enrollment composition requirements to obtain at least a Cost Contract. It should also allow such federally qualified HMO to obtain a Risk Contract subject to HCFA's judgement on the quality and fiscal soundness of the plan.**

Congress should encourage HCFA to adopt more flexible rules and regulations to reduce the paperwork burden of Medicare Cost Contracts, especially for provider services.

Congress should require HCFA to survey Cost, Risk and HCPP Contractors to get better information on the scope of benefits, types of copayments or fees, deductibles, or other limits so that more rationale policies on gap policies for Risk, Cost, and HCPP Contracts might be developed.

* * *

If you have any questions or wish to obtain additional information regarding this statement, please call our Washington Counsel, Jerrold Hercenberg at 202-778-8083 or Wendy Krasner at 202-778-8064 of the firm of McDermott, Will & Emery in Washington, D.C.

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APPENDIX A

Section 171(f) of H.R. 5252

For purposes of this section, a Medicare supplement policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed under this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employers or former employees(or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of ~~a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833.~~ an eligible organization (as defined in section 1876(b) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Acto of 1986, or during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A).[1/]

[1/] The time period for this amendment is linked to the time period in each state when the Medigap law became effective. § 1882(p)(1)(C) sets the effective date for Medigap in each state as the date that a state adopts the NAIC model standards for Medigap policies (or if the state fails to adopt the model standards than the date that Federal standards are effective) beginning after January 1, 1992. In any event, the language of H.R. 5252 provides a grace period through December 31, 1995.

APPENDIX B

COMPARISON BETWEEN MEDICARE SELECT REQUIREMENTS AND FEDERAL HMO REQUIREMENTS

1. Quality Assurance

   - Medicare Select policies require submission to a state by an issuer of a description of its quality assurance program setting forth its formal organizational structure, written criteria for selection, retention, and removal of network providers, the methods for developing such criteria, and the procedures for evaluating quality of care provided by network providers and taking corrective action when warranted. See NAIC § 10.E.4.

   - Federally qualified HMOs (HMOs) must have a quality assurance program. The program must: stress health outcomes, provide review by physicians and health practitioners of health services, use systematic data collection of performance and patient results to evaluate services, provide interpretation of data on performance to its physicians and practitioners, and provide corrective action based upon the HMO's evaluation. See 42 C.F.R. § 417.107(h).

2. Preventive Services

   - One option that a Medicare Select policy may offer is coverage of preventive services including: tetanus and diphtheria boosters, dipstick urinalysis, thyroid function tests, fecal occult blood tests, cholesterol screening, and influenza vaccines. "Reimbursement shall be for the actual charges up to 100 percent of the Medicare approved amount for each service . . . to a maximum of $120 annually." See NAIC § 8.C.9.

   - HMOs must provide preventive services (without limitation) including periodic health evaluations and immunizations. See 42 C.F.R. § 417.101(a)(8). Conventional practice among HMOs is to provide all of the preventive services allowed by a Medicare Select policy without limiting the amount that may be spent on such services.

3. Minimum Benefits

   - Medicare Select policies are required to provide at least core benefits which include coverage of Part B coinsurance except for the $100 Medicare Part B deductible. See NAIC Model Act § 6.A, § 7.B. Medigap policies are required to cover the reasonable cost of the first 3 pints of blood. See NAIC Model Act § 7.B.5.

   - HMOs must provide basic benefits, many of which do not correspond to Medicare or are subject to coverage limitations. For example, HMOs are required to provide 20 outpatient mental health visits per member per year. See 42 C.F.R. § 417.101(a)(4). HMOs are not required to provide long term physical therapy or rehabilitation services (e.g. physical therapy, occupational therapy, dialysis services), whole blood, corrective appliances, durable medical equipment at home, or certain transplantation services. See 42 C.F.R. § 417.100(d).

4. Nominal Copayments

   - Medicare Select policies must pay for Medicare Part A and B deductibles and coinsurance by filling 100% of the gaps in Medicare coverage for the NAIC model core benefits package and 100% of the deductible or coinsurance amounts payable for each of the additional benefits offered. If a Medicare Select policy offers to cover additional benefits such as the coinsurance for skilled nursing facility services, or the Part B deductible covering a range of physician, outpatient and other medical services and items, no copayments may be charged by the issuer of Medicare Select against the Medicare beneficiary. See NAIC § 6.B.

   - HMOs are authorized to charge nominal copayments. Copayments may not exceed 50% of the total cost of providing any single service offered to the HMO member or 20% of the annual aggregate costs incurred by the member. To insure that copayments are not a barrier to utilizing services, an HMO may not impose copayments in excess of 200% of the annual premium costs which a subscriber would be required to pay for an HMO policy with no copayments.
     42 C.F.R. §417.104(a)(4). Conventional practice by HMOs is to provide nominal copayments of between $5 to $25 for selected outpatient services such as physician, diagnostic, hospital outpatient or emergency, mental health, or special therapy services.

5. Medical Necessity

- Medicare Select policies must cover "Medicare eligible expenses" which are defined as expenses of the kinds covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare. See NAIC § 5.G.

- HMOs must provide or arrange for all covered medically necessary services. Because HMOs determine the medical necessity of services independently of Medicare carriers, they may disagree with approval by such carrier. For example, HMOs are sometimes more restrictive in approving DME. In addition, Medicare carriers will approve routine services furnished by non-HMO providers even if the HMO has not given authorization for such services. Whenever an HMO denies coverage, a member is entitled to appeal through the HMO's grievance procedures. See 42 C.F.R. §§ 417.100 and 417.107(g).

6. Enrollment and Underwriting

- Medicare Select requires open enrollment for any Medicare beneficiary age 65 or older who resides in the state without discriminating against individuals with adverse health conditions either in the pricing of the premium or in accepting new subscribers. See NAIC § 11.

- HMOs are permitted to enroll only persons who live within the service area it serves. See § 1301(c)(3)(A) of the HMO Act. HMOs are prohibited from discriminating in enrollment on the basis of health status and must rate premiums based upon community rating requirements which do not take into account the individual health status of the member. See 42 C.F.R. §§ 417.107(d) and 417.104(b).

7. Indemnity and Out-Of-Network Option

- The issuer of a Medicare Select policy is obligated to make available to each applicant the opportunity to purchase a Medicare supplement policy (an indemnity policy it offers without network restrictions) which has comparable or lesser benefits and does not contain a restrictive network provision. See NAIC §10 L. and M. Medicare Select policies also must provide payment for full coverage for services that are not available through network providers. NAIC § 10.H.

- An HMO must provide at least 90% of physician services through its staff, medical group, IPA, contracted physicians or combination of these. See HMO Act § 1301(b)(3)(A). HMOs are not authorized to pay for non-emergency routine services of non-participating providers. See HMO Act § 1301(b)(4).

8. Conversion

- Medicare Select requires the issuer to allow the subscriber to convert to continuation coverage under a traditional Medigap policy if HHS determines that the Medicare Select policy must be discontinued. See NAIC § 10.N.

- HMOs would need an exemption from this requirement because HMOs do not offer traditional Medigap policies and would be unable to convert their members to a traditional Medigap policy.

9. Termination of Membership

- Medicare Select issuers are prohibited from terminating or cancelling a policy or certificate except for non-payment of premium. See NAIC § 7.A.4. In addition, Medicare Select policies are required to provide protection against continuous loss after cancellation of the policy. See NAIC § 7.A.6.

- Even though HMOs may not discriminate against a member on the basis of health status in terminating or refusing re-enrollment, HMOs may terminate a member for reasons other than non-payment of premiums, including (i) the member's relocation out of the service area; (ii) the inability of the member to maintain satisfactory relations with HMO physicians; (iii) the non-cooperation of the member in following HMO policies and procedures; (iv) the fraudulent use of membership privileges. See 42 C.F.R. §417.107(d). HMOs can provide protection from continuous loss following termination of a member only through participating providers.

10. Emergency and Urgently Needed Services

- Medicare Select issuers are required to reimburse for emergency care obtained 24 hours per day 7 days per week. In addition, such issuer must disclose to subscribers on what basis it will pay for emergency, urgently need, and out of area coverage. See NAIC § 10.E.1.d., G, and I.4.

- A member of an HMO is entitled to be reimbursed for medically necessary services rendered in emergencies or when urgently needed and where the member is unable to obtain services from a participating HMO provider. Such services must be due to unforeseen illness, injury, or condition. See § 1301 (b)(4) of the HMO Act.

11. Free Look Period

- Medicare Select policies must offer a subscriber at least 30 days to reject coverage after enrolling. See NAIC § 15.

- HMOs would need authority under this requirement to recover the cost of services furnished during the free-look period if a member, who has received services, elects to cancel membership retroactively.

12. Member Protection From Provider Claims

- Medicare Select has no provision.

- HMOs are required to protect their members in case of insolvency. See 42 C.F.R. § 417.107(a)(3). It is conventional practice for HMOs to require "hold harmless" agreements with participating providers, in which providers agree not to charge an HMO's members if the HMO fails to pay the provider. Hold harmless provisions protect members in the event of insolvency and during any disagreement over the medical necessity of a claim.

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Statement of the

HOME CARE COALITION

submitted to

House Ways and Means Committee Subcommittee on Health
U.S. House of Representatives

Hearing On
"Growth in Medicare Costs"

Monday, February 6, 1995
Washington, D.C.

I. Introduction

The Home Care Coalition is pleased to submit a statement for the record of the February 6, 1995 House Ways and Means Health Subcommittee hearing on "Growth in Medicare Costs." This statement is submitted on behalf of our more than one hundred organizations on the growth of Medicare Part B costs and the need to improve the overall Medicare program.

The Home Care Coalition, founded in January of 1991, is a diverse group of organizations representing consumers and patients, family caregivers, health care professionals, providers, and manufacturers dedicated to serving people in their homes. The mission of the Coalition is to enhance consumer access to quality home care services, supplies, and equipment, and it focuses attention on providing education and communications advocating the benefits of home care to policymakers and the public.

II. Medicare Should Capitalize on the Cost-effectiveness of Home Care

The Home Care Coalition is pleased that the House Ways and Means Committee Health Subcommittee is carefully examining the overall Medicare program to find ways to improve its cost-effectiveness and its quality of service. The Home Care Coalition has long advocated that Medicare, while a base for coverage of home health services, supplies and equipment, should be revised to include therapies, treatments, and equipment which enhance clinical outcomes and quality of life for individuals with both acute and long term care needs. Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) coverage does not cover many cost-effective home medical services, supplies, and equipment which utilize cost-effective technology. For example, the 1965 Medicare statute's restrictive language prevents beneficiaries from taking advantage of cost-effective home care, such as home infusion therapy and respiratory therapy. These therapies should be covered but currently are not because of the language of the outdated 1965 Medicare statute. As the 104th Congress examines the rise in Medicare and other health care costs, it should look to home care as a solution.

III. Factors Contributing to Medicare Part B Growth

We caution the Health Subcommittee not to look at the growth of Medicare Part B in a vacuum but rather to consider the demographic and historical factors which have increased the use of home care versus institutional care. These factors include (1) the aging of the elderly population which is likely to continue to dramatically increase the use of home care, (2) advancements in sophisticated technology which now enable patients to receive high technology care (*e.g.* home infusion therapy, oxygen therapy) in their homes rather than in the hospital, and (3) the 1983 implementation of the Medicare hospital prospective payment system which has led to patients being released from the hospital "quicker and sicker." These factors, coupled with patients' increasing preference for care at home, have contributed enormously to the growth of home care and the shift from Medicare Part A hospital care.

Reasons For Growth

- Increased number of beneficiaries
- Increased number of elderly beneficiaries
- Increased support for home care by physicians
- Increased support for home care by consumer and beneficiaries (recognition of the value in returning workers to work, such as the Americans With Disabilities Act)
- Increased home care utilization to reduce more costly institutional utilization (DRGs)

Not Reasons For Growth

- Medicare fee schedules have not increased, in fact, the have decreased
- Medicare coverage guidelines under new DMERCs are focused and tight
- Carrier consolidation has focussed carriers' administration of the DMEPOS benefit

IV. Home Care Is Cost-Effective

The growth of Medicare Part B expenditures, however, is not attributable to inappropriate utilization. Appropriate home care services decrease costly stays in hospitals and nursing homes, and increase patients' potential to become productive and participatory members of society. As the following summary chart shows, a number of studies show that home care is more cost-effective than hospital care:

Monthly Cost of Hospital Versus Home Care Under Selected Conditions

CONDITION	COST OF HOSPITAL CARE	COST OF HOME CARE	DOLLAR SAVINGS	DIFFERENCE
Infant with breathing and feeding problems	$60,970	$20,209	$40,761	66.8%
Nutrition infusions	$23,670	$9,000	$14,670	62%
Antibiotic infusions	$7,290	$2,070	$5,220	71.6%
ALS Patient on mechanical ventilation	$366,852	$136,560	$230,292	62.8%
Patient requiring respiratory support	$24,715	$9,267	$15,488	62.5%
Quadriplegic w/spinal chord injury	$23,862	$13,931	$9,931	41.6%
Person with cerebral palsy	$8,425	$4,867	$3,568	42.3%
Bone Marrow infection	$16,000	$5,000	$11,000	68.6%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$9,153	$6,589	41.9%
Oxygen-dependent children with a tracheostomy	$12,236	$5,304	$6,932	56.7%
AIDS care	$23,190	$2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%
Cancer chemotherapy	$10,500	$3,500	$7,000	66.8%
Kidney dialysis	$2,000	$1,200	$800	40.0%

Sources: from Olsten HealthCare, Aetna Life & Casualty Co., National Association for Home Care, 1993, 5th International Conference on Pulmonary Rehabilitation and Home Ventilation, Denver, Colorado, 1995.

As this chart shows, home care is considerably more cost-effective than hospital care for a number of different medical conditions. The information in the chart is a compilation of published reports and studies from a number of sources, including those listed above. Clearly, the percentage of the difference in costs between the home care and hospital setting -- as high as 87.8 percent -- indicates that home care should receive the highest consideration in efforts to lower costs in the health care delivery system.

The following chart shows the cost-effectiveness of home care per episode in comparison to hospital inpatient treatment:

COST COMPARISON OF TREATMENT OF HIP FRACTURE, COPD AND PNEUMONIA IN ALS

CONDITION	HOSPITAL INPATIENT TREATMENT	HOME TREATMENT	COST SAVINGS
Hip Fracture Patients	**$6,708.14**	**$4,692.05**	**$2,016.09 per episode**
COPD	**$3,547.87**	**$3097.75**	**$450.12 per episode**
ALS Patient	**$3,751.26**	**$3,491.98**	**$259.28 per episode**

Source: Lewin ICF, "Economic Analysis of Home Medical Equipment Services," May 29, 1991.

There are also a number of studies which have showed states' effectiveness in moving to cost-effective home care, including the following:

- **GAO Report on Home Care Cost-Effectiveness**

The General Accounting Office's (GAO) August 1994 report, *Medicaid Long Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (GAO-HEHS 94 167) shows the cost-effectiveness of home and community-based long term care programs implemented in Washington, Oregon and Wisconsin. The GAO study reports that as a result of their shift to home and community-based care, these states have been able to serve more beneficiaries with the Medicaid and state dollars they have available. The study states, "On a per-beneficiary basis, home and community-based care is considerably less expensive than nursing facility care." The report also states that per-user spending for nursing facility care has been rising faster than for home and community-based care.

Washington
The report found that Washington's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $2,023 in 1993 compared with $419 for home and community-based users.

Wisconsin
Wisconsin had a net savings in per-person public expenditures associated with home and community-based care of 16 percent.

Oregon
Oregon saved $227 million between 1981 and 1991 by using home and community-based care and reduced the number of nursing facility beds significantly. Oregon's average monthly expenditure per user for nursing facility care for the aged and disabled averaged $1,657 in 1993 compared with $420 for home and community-based users.

Other Reports

- **New York's "Nursing Home Without Walls" State Senate Report**

New York's "Nursing Home Without Walls" program takes individuals who are eligible for Medicaid and allows them to be cared for at home if the costs so incurred are 75 percent or less than the cost of comparable nursing home care. New York's State Senate studies show the state saved 50% of the cost for these patients which would have been incurred had they been placed in a nursing home.

- **New Mexico Waiver Program**

New Mexico's waiver program for people with AIDS estimates a savings of $1100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs $1000 a month for home care compared to $2,100 a month for skilled nursing facility care. New Mexico reports that only about 47% of patients receiving waiver services are hospitalized in a given year compared to 70% of those not under waiver.

- **National Governors Association 1992 Resolution**

The National Governors Association's 1992 resolution recommended the elimination of the current institutional bias in public programs such as Medicaid. The governors are asking for more flexibility to make greater use of home care as the more preferred and cost-effective method of meeting the growing need for long-term care.

V. Home Care Coalition Recommendations

The Home Care Coalition has identified specific ways to improve access to home care. These legislative initiatives recognize and support home care as a cost-effective and patient-preferred alternative to institutional care. Legislative initiatives to encourage home care that the Coalition supports include patient choice of provider, caregiver issues, coverage of home IV and respiratory therapy services, reimbursement issues, and quality assurance mechanisms for the patient receiving home care services, supplies and equipment.

Home Care Coalition Recommendations Address Fraud and Abuse

The Home Care Coalition agrees with the Ways and Means Health Subcommittee that the Medicare program should be revised to safeguard against fraud and abuse and to ensure that beneficiaries receive high quality service. For example, the Home Care Coalition supports home infusion and respiratory therapy quality standards in home care. The Home Care Coalition strongly supports more rigorous supplier service standards to ensure that Medicare beneficiaries receive a consistent level of quality service. In addition, the Home Care Coalition supports a home care data system to improve data management, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized home care data management to facilitate communications among providers and payors. These are just some of our proposals to improve Medicare Part B to prevent fraud and abuse and to improve quality.

Specifically, the Home Care Coalition supports the following legislative initiatives:

Caregiver Issues

Caregiver Tax Credit - Provide $500 refundable tax credit for individuals caring for a chronically disabled grandparent, parent, spouse or child in their home.

Personal Assistant Services/Attendant Care Demonstration - On a demonstration or pilot project basis, require all payors (Medicare, Medicaid and private payors) to provide defined period of personal assistant services/attendant care services to persons with disabilities requiring assistance with activities of daily living.

Caregiver Safety and Well-Being - Require all payors to take into consideration the safety, health and well-being of the primary caregiver when determining the medical necessity of, and prescribing, appropriate home health services and home medical equipment (HME). Authorize payors, including Medicare, to pay for specific items and upgrades of otherwise medically necessary HME when, in the clear and documented clinical judgment of the prescribing health care professional, the HME recommended will significantly reduce the risk of injury to the unpaid primary caregiver.

Patient Choice

Patient Choice of Provider - Require health plans to allow a patient to go to a provider of their choice outside of their health plan's network at no more than a reasonable charge to the patient.

Patient Choice/Upgrade - Amend the Medicare law to authorize beneficiaries to pay suppliers who agree to take assignment on their claims the balance above the Medicare allowable for the equipment which has functional or other features exceeding those of the item determined by Medicare to be covered. Further amend the Medicare statute to clearly continue to allow a supplier to submit any claim for payment under assignment for an item the beneficiary chooses to upgrade.

Coverage and Reimbursement Issues

Home Care Benefit Package - Include legislatively defined comprehensive home care services, supplies and equipment in any standard health benefit package.

Medicare Coverage for respiratory therapy services - Cover respiratory therapy services under Medicare.

Medicare Coverage for home intravenous (IV) therapy - Cover home IV therapy services under Medicare.

Medicare Coverage for occupational therapy - Include occupational therapy as a qualifying service for Medicare Part A home health services.

Non-Discrimination against home care - Provision would eliminate any financial or other disincentives for utilization of home care under Medicare or private payor systems. (Requiring home care beneficiaries to pay a co-payment for care is a disincentive to use home care when there is no co-payment required for institutional care.)

Reimbursement for physician home care visits - Medicare and other payors should reimburse the physician at a reasonable fee for medically necessary home care visits to a patient in the home.

Quality Assurance

Certification of Suppliers; Quality Standards - Establish Medicare supplier standards based on the complexity of the services provided for suppliers to be able to bill Medicare for durable medical equipment, prosthetics and orthotics (DMEPOS). For example, suppliers providing respiratory equipment and related services would have to meet more rigorous standards than suppliers providing only "traditional" HME such as hospital beds and canes. Further, suppliers providing certain "life-supporting" equipment and related services would be required to meet even higher standards.

Miscellaneous

Home Care Data System - Provide for a series of data management improvements, including administrative simplification, standard claims processing forms (paper and electronic) for all public and private payors, and standardized home care data management to facilitate communications among providers, payors, *etc*.

Home Care Council - Establish a national council on home care to make recommendations to Congress, and to develop proposed changes in regulations and policy related to the provision of home care. The national council would make recommendations on simplifying consumer understanding of home care benefits and payments. The Council would include consumers, providers and fiscal intermediaries. The Council would make recommendations to the Secretary on streamlining procedures for approving coverage criteria and appropriate reimbursement for new technology products.

VI. Conclusion

The Home Care Coalition commends the Ways and Means Health Subcommittee for its efforts to explore ways to improve the Medicare program. The Home Care Coalition believes that the answer is not to cut Medicare Part B, which is a cost-effective alternative to institutional care, but rather to revise the Medicare statute to consider cost-effective technologies which Medicare currently does not cover. For example, the 1965 Medicare statute's restrictive language prevents beneficiaries from taking advantage of cost-effective home care, such as home infusion therapy and respiratory therapy. These therapies should be covered but currently are not because of the language of the 1965 Medicare statute.

As our population ages and there is more utilization of home care because patients prefer home care and sophisticated technology allows for home care treatment, Medicare must accommodate advances in medical technology to continue the cost-effective use of home care versus expensive care in a hospital setting. If access to more home care services were provided to patients hospital costs could be reduced. There is no question that savings could be realized, provided that utilization controls based on medical necessity were also in place. The Coalition is concerned that Congress not seek to solve the cost problems by simply limiting the benefits offered to patients without a more global consideration of the most appropriate and cost-effective site of care.

The Home Care Coalition

Advocate for Elderly and Disabled
The ALS Association
American Association for Continuity of Care
American Association for Respiratory Therapy
Cystic Fibrosis Services, Inc.
Daughters of Charity National Health System
HIDA Home Care
Health Industry Manufacturers Association
Home Health Care Dealers Co-op
Invacare Corporation
National Association of Retail Druggists
United Ostomy Association

STATEMENT OF THE NATIONAL ALLIANCE FOR INFUSION THERAPY

The National Alliance for Infusion Therapy ("NAIT"), an association of health care providers and manufacturers involved in the provision of home and alternate-site infusion therapy, submits the following comments to the Subcommittee on Health of the House Ways and Means Committee for its hearing on extraordinary growth in Medicare costs. NAIT members serve much of the infusion therapy patient population, providing nursing and pharmacy services, equipment, drugs, nutrients, and supplies.

Infusion therapy involves the administration of drugs or liquid nutrients to patients with cancer, infections, severe pain, gastrointestinal disorders, and a wide variety of other illnesses and conditions. NAIT members share the concerns of the Subcommittee about rising Medicare costs and increasing fraud and abuse, and are pleased to contribute to the discussion on how to address these problems with respect to home infusion therapy services. We will discuss each issue separately and will propose a possible course of action that we believe addresses both.

Compared to other home care services, home infusion therapy is relatively new in terms of its utilization. Only in the last fifteen years has infusion therapy become widely available in the home, as advances in technology and changing nursing and pharmacy practice have made it possible to deliver complex treatments outside the hospital. The cost savings associated with home infusion therapy as compared to inpatient care have prompted both private insurers and the Medicare program to provide coverage for home infusion therapy. Medicare began to cover the nutritional therapies (parenteral and enteral nutrition) in 1981. The enactment of a Medicare prospective payment system for hospitals in 1983 further fueled the demand for home care services, including home infusion therapy, as patients were discharged from the hospital at earlier stages of recovery.

As the demand for home infusion therapy services has grown, so has the universe of providers serving patients in their homes. NAIT was formed in large part to provide leadership in the area of quality and to responsibly address home care policy as it pertains to home infusion therapy.

Medicare Home Infusion Therapy Costs

We have long been concerned about Medicare policy in the area of home infusion and its effect on rising Medicare expenditures. While the portion of Medicare costs attributable to home infusion therapy is actually small in relation to the full spectrum of home care, this is still an area that warrants serious change. Currently, the Medicare program cannot determine what it is "buying," in effect, with the dollars it pays for the various infusion therapies, or whether its beneficiaries are being served by qualified providers.

This situation is largely due to how Medicare covers home infusion therapy. To explain briefly, Medicare treats the nutritional therapies as prosthetic devices under Part B of the program. Certain other infusion therapies are covered under the durable medical equipment benefit, also under Part B, at the discretion of the regional carriers. In both instances, the "trigger" for coverage is the patient's need for a device or piece of equipment. Neither the prosthetic device benefit nor the durable medical equipment benefit was designed to accommodate a multidisciplinary therapy that involves services as well as products, as home infusion therapy certainly does. From the perspective of the program, all that is officially covered under these two benefits are the tangible items, such as tubes, catheters, pumps, nutrients, or drugs. Professional services, which are critical to ensure patient safety (especially for the frail elderly), are not explicitly covered.

Over the years, this has created a situation where patients must qualify for coverage based on illogical, and sometimes irrelevant, criteria. Instead of determining coverage based on the medical necessity for the treatment, Medicare instead requires patients to demonstrate a medical need that fits into the narrow definitions of the prosthetic device benefit or the durable medical equipment benefit. This has had ramifications in terms of Medicare costs, in that it discourages cost-effective use of resources based on patient need. For example, many patients may not need a pump to deliver their prescribed antibiotic therapy, yet Medicare will not cover the therapy unless a pump is used in the treatment (since the coverage is based on the use of an item of durable medical equipment). This needlessly creates an incentive to use a pump, which is more costly than other alternatives such as a traditional gravity-drip mechanism, or worse, to keep the patient in the hospital at a significantly greater cost than home care.

These illogical rules can also cut the other way. Because the program only explicitly covers items and not professional services, officials at the Health Care Financing Administration

(HCFA) are constantly looking for ways to reduce payment for infusion by basing it only on the provider's acquisition cost of products. This is disingenuous, in our view, because HCFA is well aware that most beneficiaries need the services of nurses and pharmacists to ensure safety and efficacy. HCFA knows, for example, that these therapies are invasive and present the possibility for severe, sometimes life-threatening, complications if they are not administered and monitored properly. Yet program officials persist in suggesting budget cuts that would seriously undermine providers' ability to ensure patient safety.

One such proposal was put forth late last year in the health reform debate, which NAIT strenuously opposed on the grounds that it was completely inconsistent with other provisions in the bill and, if implemented, would severely hamper providers' ability to deliver quality service. The proposal would have allowed HCFA to competitively bid for parenteral and enteral nutrition (PEN) services. Under the proposal, providers would submit bids based on the cost of supplying only PEN nutrients and supplies, not professional services. Medicare would be allowed to contract with one PEN provider per geographic area. The obvious incentive for providers would be to submit bids that do not reflect the costs of employing nurses and pharmacists. This would effectively drive many quality PEN providers out of the Medicare program and reduce payment to an unreasonably low level. Or, it would force a national redefinition of PEN therapy, so that in the future all services would simply disappear from policymakers' and payers' perception of these therapies. That would be a genuine tragedy, and one clearly inconsistent with the patients' interests.

We want to make it clear that we intend to cooperate with Congress to develop budget policies in the area of home infusion therapy that make sense for both the program and patients. Over the past eight years, PEN has contributed substantially to deficit reduction efforts, with payment rates being frozen several times over that period. However, we intend to oppose any cuts that would have a negative effect on quality for Medicare beneficiaries and which would make it impossible for responsible providers to compete for Medicare patients.

Potential for Fraud and Abuse in Home Infusion Therapy

As mentioned earlier, one of the primary reasons for forming NAIT was to promote sound public policy and responsible behavior on the part of providers and manufacturers. We continue to seek reforms designed to protect patients from unscrupulous providers and to clarify the rules under which providers and manufacturers operate.

For example, while NAIT has always supported and continues to support the critical role of physicians in the provision of therapy, we believe that third party payers, not providers, should be paying them for the clinical management services they provide. We supported the Stark ban on physician self-referral that was enacted as part of OBRA-93, as well as the extension of the ban to all payers that was part of virtually every major health reform bill last year. As show of their support for this policy, all NAIT providers, which comprise most of the national providers in the industry, recently decided to divest themselves of any existing private-sector financial relationships with physicians.

NAIT has always pushed for greater oversight of home infusion therapy providers to ensure quality and patient safety. We believe that the current environment does not offer patients, either in the private or public sectors, sufficient assurance that they are receiving care from a qualified provider. While state licensure laws and voluntary accreditation offer some measure of protection, we believe a more comprehensive approach is needed. We have proposed that home infusion therapy providers be given "provider" status under Medicare and be required to meet conditions of participation in order to provide care to beneficiaries. These same standards could easily be adapted to the private sector. Most of the major health reform bills last year included NAIT's suggested language on these requirements, as did a bill introduced last year by Congressman Sherrod Brown (D-OH).

Clearly, the absence of Medicare standards in the area of home infusion contributes to the potential for poor quality care. Currently, providers of home infusion therapy have only to acquire a "supplier" number and meet very minimal requirements in order to provide care to Medicare beneficiaries. As mentioned earlier, infusion therapy is an invasive treatment involving the administration of drugs and nutrient solutions directly into a patient's bloodstream or digestive tract. The potential for infection and adverse reactions to the solutions infused is very real, and patients must be monitored closely. Nurses must know how to spot complications and respond immediately to prevent injury to the patient. Pharmacists must be trained in how to compound sterile solutions according to precise prescriptions. The Medicare program, in our view, simply takes for granted that its beneficiaries are getting the benefit of such expertise; that may well be true, at the moment. However, HCFA's efforts to simply reduce provider payments while maintaining coverage only in the context of the prosthetic device benefit and the durable medical equipment benefit will guarantee that quality care may not be presumed in the future. It is clear that Medicare will neither recognize nor explicitly pay for professional services until change is mandated by Congress.

A Possible Solution to Rising Costs and Current Regulatory Problems

As stated earlier, NAIT is concerned about how to promote efficient use of Medicare dollars for infusion therapy and better quality of care for beneficiaries, and we believe that we have a solution that will address our concerns as well as those of Congress and the Medicare program. We have long supported a reengineering of Medicare coverage of home infusion therapy that would change the way Medicare defines infusion therapy, as well as the way Medicare pays for it. It would involve the creation of provider quality standards so that patients would have some assurance that they are receiving good care. Put simply, it would deal with infusion therapy in a straightforward, patient-centered manner and instill some accountability where there has traditionally been little or none.

Such changes have been considered by Congress several times, starting in 1988 with the Medicare Catastrophic Coverage Act, and most recently in the comprehensive health reform proposals advanced during the last two years. We would like to work with Congress this session to ensure they are enacted.

Congress must make these changes if the Medicare program is to have any hope of instilling accountability in its administration of home infusion therapy benefits. The current system simply does not encourage it, as HCFA is aware. In fact, HCFA officials testified before Congress in September of 1993 on the inadequacy of current coverage policies for home infusion therapy. However, instead of actively working for change, HCFA instead persists in making budget and other decisions that only exacerbate the problems and potentially endanger beneficiaries.

We suggest one of two possible courses of action. One would be to create a freestanding home infusion benefit within the Medicare program. Home infusion therapy providers would be given "provider" status, and HCFA would develop quality standards in the form of conditions of participation. Services and products to be covered could be clearly spelled out, and HCFA could develop a fee schedule based on what a patient actually needs and what is actually provided to that patient.

The other possibility is to allow Medicare beneficiaries to receive infusion therapy services as part of private-sector insurance coverage that is funded by the Medicare program through a voucher system. For example, Medicare could determine a baseline payment for home infusion therapy benefits and require that private payers meet certain requirements in order to participate. The advantage it offers is that it puts the administration of infusion benefits in the hands of the private sector, which for the most part has become much more adept in this area than the Medicare program. There are a variety of ways such a system could be structured, and we would be pleased to work with Congress on this proposal.

Either of the above proposals would vastly improve the ability of the Medicare program to determine the true cost and quality of home infusion therapy services its beneficiaries are receiving, and would assure providers that payment will be based on all elements of therapy, not simply the product components. Most importantly, beneficiaries would have some comfort that they are receiving care from qualified providers. We believe that these proposals are truly in the interest of all parties, and we look forward to working with Congress to achieve our mutual goals.

Thank you for the opportunity to submit these comments for the record to the Subcommittee. If Subcommittee members or staff have any questions about our testimony, please contact Alan Parver or Jana Sansbury at (202) 347-0066.

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STATEMENT OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF ORTHOTICS AND PROSTHETICS

INTRODUCTION

The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is a national, non-profit organization comprised of orthotic and prosthetic health care practitioners (orthotists and prosthetists) who clinically and technically design, fit, and fabricate orthopedic braces and artificial limbs (orthotics and prosthetics) for this nation's two million amputees and other people with physical disabilities requiring orthotic and prosthetic care. Quality orthotic and prosthetic care can be extremely cost-effective by enabling people with disabilities to achieve high levels of independence and function in the workplace, in the home, and in all aspects of community life. Appropriate orthotic and prosthetic care also helps prevent secondary disabilities and decreases long term health and welfare costs to society.

Orthotic and prosthetic services are reimbursed under Part B of the Medicare program through a fee schedule known as the "L-codes." Although the four recently-created Durable Medical Equipment Regional Carriers (DMERCs) currently administer reimbursements for orthotics and prosthetics under the Medicare program, there is a major distinction between durable medical equipment (DME) and orthotic and prosthetic (O&P) services that justifies separate consideration and treatment when regulating these sectors of the health care field.

ENSURING QUALITY ORTHOTIC AND PROSTHETIC CARE

Practitioner Education

A critical distinction between the provision of durable medical equipment and the provision of orthotic and prosthetic services entails the level of education and training necessary to provide comprehensive O&P services. Comprehensive orthotic and prosthetic care requires highly specialized and trained practitioners in order to design, fit and fabricate a customized artificial limb or orthopedic brace for the particular needs of each patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes and complex contours, is fundamentally different from most types of durable medical equipment which tend to be more generic, pre-fabricated, and less clinically intensive to provide.

In addition, significant variation exists in the delivery of quality orthotic and prosthetic services, primarily due to the range of physical disabilities orthotic and prosthetic care can benefit and the explosion of technology over the past decade. To keep abreast of clinical and technological developments, individual practitioners participate in continuing education, research, and the frequent exchange of information among professionals. The orthotic and prosthetic profession has a defined body of clinical and technical knowledge and a core of over 3,000 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities.

Certification and Accreditation

Currently, the American Board for Certification in Orthotics and Prosthetics (ABC) offers the highest level of credentialing standards for orthotists and prosthetists and is the most widely recognized credentialing organization for orthotic and prosthetic services. ABC was founded in 1948 and conducts a comprehensive credentialing process for both orthotic and prosthetic practitioners as well as facilities in which they provide their clinical and technical services.

ABC-certified orthotists and prosthetists are the only orthotic and prosthetic practitioners recognized by the American Medical Association (AMA) as true orthotic and prosthetic allied health professionals. The education requirements for ABC certification are the only educational pathways recognized by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the U.S. Department of Education.

The ABC awards practitioner accreditation in three categories, Certified Orthotist (C.O.), Certified Prosthetist (C.P.), and Certified Prosthetist/Orthotist (C.P.O.). The minimum entry level requirements for practitioner education and certification are:

(a) a bachelor of science degree in orthotics and prosthetics or a bachelor of science degree in a related allied health or engineering field along with successful completion of specific undergraduate courses in orthotics and prosthetics at accredited schools,

(b) one year of clinical residency in each discipline, and

(c) successful completion of a comprehensive written, oral, and clinical examination for practitioners administered by the American Board for Certification in Orthotics and Prosthetics.

These stringent standards help ensure that ABC-certified orthotic and prosthetic practitioners are competent to provide the full range of comprehensive O&P care to patients with a multitude of varying disabilities. This high level of education and training helps assure quality in the clinical service element inherent in the delivery of these highly technical customized devices.

The Service Element of Orthotic and Prosthetic Care

Quality orthotic and prosthetic care is as much a professional service as it is a device that results from this service. While there is a service component in the delivery of some types of durable medical equipment, such as the design of customized wheelchairs and the delivery of certain home health services, orthotic and prosthetic care is generally far more service-oriented and specialized to the needs of each patient. Yet, when Congress and the Health Care Financing Administration (HCFA) have regulated durable medical equipment in the past, through fraud and abuse and reimbursement reforms for instance, they have tended to blindly cast the same net over the very different fields of orthotics and prosthetics.

The lack of separate treatment between DME and O&P has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. This failure to separately address DME and O&P often creates unintended consequences and unfairly punishes the orthotic and prosthetic fields for problems in other areas of the health care delivery system. Two recent examples of this is the inappropriate reclassification by HCFA of custom orthotic seating systems as "inexpensive/routinely purchased" DME and the fraud and abuse orthotic body jacket investigation conducted by the Office of Inspector General.

HCFA'S RECLASSIFICATION OF ORTHOTIC SEATING SYSTEMS AS DME

Custom orthotic seating systems are designed and fabricated to meet the unique needs of people with severe physical disabilities requiring seating support usually associated with long term wheelchair use. Custom orthotic seating systems are needed in this instance to avoid serious health complications--such as decubitus ulcers and spinal collapse--and to maintain functional activities of daily living. Depending upon the severity of the patient, these customized orthoses range in cost from a few hundred to several thousand dollars. Until recently, HCFA reimbursed these orthoses using an orthotic L-code and individually considered each device to determine a reasonable fee.

With the creation of Medicare's Durable Medical Equipment Regional Carriers, these custom seating orthoses were inappropriately reclassified as "inexpensive/routinely purchased" durable medical equipment and assigned three different "K-codes," obviously not part of the orthotic and prosthetic L-code system. Instead of individually considering the fee for each custom seating orthosis claim, HCFA and the DMERCs now reimburse claims for these devices at a fixed allowable fee, regardless of the level of complexity involved in designing and developing the individual orthosis. Despite the fact that the descriptions for these three new K-codes include the words, "orthotic" and "custom fabricated,"--which clearly demonstrate the propriety of reimbursing these devices under the L-code system--they continue to be treated as "one size fits all" durable medical equipment.

The DMERCs have recently stated that this action was taken because these custom orthotic seating systems are merely permanent accessories to wheelchairs and are not transferable. While custom orthotic seating systems are often fabricated to mount onto a wheelchair, the DMERC's rationale fails to consider the frequent use of these devices, particularly among children, as transferable between wheelchairs, as car seats, and in a variety of other situations, including allowing one to sit independently supported at a table to eat a meal.

HCFA and the DMERCs have been fully informed of this problem throughout the past several months, but have failed to remedy the situation to date. As a result, some of the very specialized orthotists who fit and fabricate these orthoses have begun to deny these services to Medicare beneficiaries. We point to this situation as an example of the problem of not recognizing the separate treatment of DME from orthotics and prosthetics. We request this Subcommittee, HCFA, and the DMERCs to consider reincorporating these newly-created K-codes into the L-code system where custom orthotic seating systems truly belong and determining fees for these orthoses based on individual consideration of each claim.

THE OFFICE OF INSPECTOR GENERAL'S TESTIMONY

The Office of Inspector General (OIG) testified today on the issues of fraud and abuse in the area of durable medical equipment generally, and specifically as to the investigation of "orthotic body jackets." The OIG testified that "payments for [orthotic body jackets] went from $217,000 in 1990 to $18 million in 1992. We estimated that 95% of those payments were for devices more properly categorized as [prefabricated wheelchair] seat cushions, rather than body jackets." Seat cushions are items of durable medical equipment that cost Medicare $200 to $300 per unit. An "orthotic body jacket" is a thoracic-lumbar-sacral orthosis (TLSO) designed for the treatment of spine or trunk musculoskeletal disorders such as fractures, spinal cord injuries, post surgical stabilization, scoliosis, congenital deformities, etc. The custom design and fitting of a TLSO requires sufficient medical knowledge of these complex disorders for one to possess the clinical and technical skills necessary to provide this complex and comprehensive orthotic service.

This type of orthotic body jacket is identified as L-0430 in the Medicare O&P reimbursement system and has a reimbursement value of approximately $1,000 to $1,200. According to the OIG report, unscrupulous providers began submitting claims for simple seat cushions using the L-0430 reimbursement code in 1990. By the time HCFA identified this fraud and abuse, nearly $18 million in fraudulent claims had been reimbursed under this L-code in 1992 alone.

What the Inspector General did not mention was that the 5% of "orthotic body jackets" that were deemed by the OIG report to be "legitimate" claims were, in almost every instance, provided by certified orthotists "whose primary occupation is supplying orthotic and prosthetic devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics." OIG Report , p.4.

THE IMPORTANCE OF CONDITIONS OF COVERAGE

Recognition of provider credentials in the delivery of quality orthotic and prosthetic care is a critical point that we strongly request this Subcommittee consider when attempting to legislatively ferret out health care fraud and abuse in the Medicare program. NAAOP believes that an effective way to curb the type of fraud and abuse that occurred with orthotic body jackets would be to establish conditions of coverage for reimbursement under the orthotic and prosthetic L-codes. By limiting reimbursement of orthotic and prosthetic services to qualified orthotists and prosthetists who are certified to provide these services, HCFA could dramatically reduce the likelihood of this type of fraud and abuse in the future, as well as, the additional costs of adjudicating these fraudulent claims.

Currently, as a practical matter, any provider who obtains a Medicare billing number can submit a claim for orthotic and prosthetic reimbursement. Until 1992, HCFA's Medicare policy carriers manual on orthotic and prosthetic coverage restricted reimbursement to ABC-certified orthotists and prosthetists. HCFA changed its policy to allow O&P reimbursement to any provider credentialed by a membership organization of the National Organization for Competency Assurance (NOCA). NOCA is not a credentialing organization, but rather a membership organization open to all organizations interested in credentialing issues.

Realizing this error in recognizing the NOCA and instead of limiting reimbursement to practitioners qualified to provide comprehensive orthotic and prosthetic care, HCFA further expanded the range of providers eligible to provide O&P services reimbursable under the Medicare L-codes in September 1994. HCFA, therefore, currently has no substantive restrictions or apparent monitoring procedures as to who is qualified to submit orthotic and prosthetic claims under the Medicare program.

HCFA, has potentially exacerbated the likelihood for the type of fraud and abuse that occurred with orthotic body jackets by recognizing and allowing "anyone credentialed by any certification organization in orthotics and prosthetics" to acquire an O&P provider specialty code and use the L-code designations in submitting orthotic and prosthetic reimbursement claims. This HCFA Medicare carriers manual policy change only increases the likelihood for fraud and abuse and provides virtually no control over the use of the O&P L-codes. Further, HCFA's relaxation of its conditions for orthotic and prosthetic coverage may lead to further proliferation of "new" orthotic and prosthetic credentialing organizations wishing to meet the relaxed requirements for orthotic and prosthetic reimbursements.

The creation of orthotic and prosthetic conditions of coverage under the Medicare program, therefore, would serve to promote quality control of orthotic and prosthetic health care services provided to Medicare beneficiaries and would lead to easy identification of fraudulent and abusive activities by unqualified providers. HCFA should consider reincorporating the ABC practitioner certification and facility accreditation standards into its conditions for O&P coverage. These certification and accreditation standards include physical facility requirements and the prerequisite that an ABC-certified practitioner be employed full-time in an O&P facility.

CONCLUSION

NAAOP welcomes the opportunity to work with this Subcommittee, the Health Care Financing Administration, and the Durable Medical Equipment Regional Carriers to eliminate fraud and abuse in the Medicare program, to appropriately regulate orthotics and prosthetics separately from durable medical equipment, and to ensure the provision of the highest quality orthotic and prosthetic care to Medicare beneficiaries. Thank you.

National Association of Long Term Hospitals

DIRECTORS

STANFORD ALLIKER
Levindale Hebrew Geriatric Center and Hospital
Baltimore, MD

ROBERT BARRIO
Masonic Home and Hospital
Wallingford, CT

SCOTT BATULIS
Bethesda Lutheran Medical Center
St. Paul, MN

GERRY BRUECKNER
Baylor Center of Restorative Care
Dallas, TX

MARGARET CRANE
Barlow Respiratory Hospital
Los Angeles, CA

CONSUELO DIAZ
Lac-Rancho Los Amigos Hospital
Downey, CA

STANLEY FERTEL, Treas.
Jewish Memorial Hospital
Boston, MA

EARL GILREATH
Drake Center
Cincinnati, OH

DONALD GOLDBERG, Pres.
New England Sinai Hospital
Stoughton, MA

KATHERINE ILL, MD
Hospital for Special Care
New Britain, CT

SAMUEL LEHRFELD
Goldwater Memorial Hospital
New York, NY

MICHAEL ROMAN
Healthwin Hospital
South Bend, IN

PATRICIA RUSH, MD
Oak Forest Hospital
Oak Forest, IL

GENERAL COUNSEL

EDWARD D. KALMAN
Behar & Kalman
Boston, MA

February 16, 1995

BY OVERNIGHT MAIL

Philip D. Moseley
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Hearings on Medicare Issues

Dear Mr. Moseley:

These comments are being submitted on behalf of the National Association of Long Term Hospitals ("NALTH") for inclusion in the printed record of the Subcommittee on Health's hearings on Medicare issues. The hearings were held on February 6, 7, and 10, 1995. We welcome the opportunity to submit these written comments. NALTH invites participation in future hearings which the Subcommittee on Health may hold on Medicare issues related to long term care hospitals and the patient population they serve. These comments address three issues which NALTH believes are important to the future of the Medicare program.

1. Selective rebasing for long term hospitals which meet a disproportionate share test;
2. Issues related to Medicare patients who "crossover" to Medicaid status; and
3. Opposition to a moratorium on new long term hospitals.

BACKGROUND ON NALTH

NALTH's member hospitals are typically not for profit and have participated in the Medicare program for many years. Most of NALTH's members have participated in Medicare from the inception of the program. NALTH member hospitals are long term hospitals as that term is defined in the Social Security Act and implementing regulations. Long term hospitals have a variety of programs to serve the a diverse, catastrophically ill and disabled population. In areas where long term hospitals do not exist, these patients remain in PPS hospitals as "extreme outliers" or, in some instances, experience repeat admissions between PPS hospitals and nursing facilities.

ISSUES

I. Selective Rebasing of Disproportionate Share Long Term Hospitals.

A. The Problem.

Medicare currently pays long term care hospitals amounts which in many cases are well below actual costs. The target amount for most NALTH member hospitals is based on costs incurred in 1982 or 1983 or later years for a hospital which joined the Medicare program after 1983. These base year costs are increased by update factors, however, the update factors are below established hospital market basket indices and fail to reflect changes in treatment methods, technology, labor and other costs which increased at rates in excess of the update factors.

B. Proposal.

NALTH proposes selective rebasing of long term care hospitals to a more current year. To qualify for rebasing, hospitals would be required to satisfy two criteria. First, the hospital must establish that it has two consecutive years of losses (i.e., Medicare costs were greater than the TEFRA target amount). Second, the hospital must meet a low income patient load test. The low income patient load test would require that the hospital's Medicaid and Medicare SSI population equal 25% or more of its patient population, or that the hospital had been certified as a long term care hospital on or before fiscal year 1989 and was located in a state which provides no coverage under its Medicaid program for patients who have exhausted the Medicare day limit, i.e., 150 days, and become Medicaid eligible.

The Congressional Budget Office has previously scored this proposal to cost $4 million in 1994 and $5 million each year thereafter. A copy is attached as Attachment "A".

II. Medicaid Issues Related to Medicare Beneficiaries Who Exhaust Their Medicare Hospital Day Limit Benefit.

A. The Problem.

The Medicare program provides ninety (90) days of inpatient hospital coverage in any given spell of illness and a one time use of sixty (60) additional days which constitute so-called life time reserve days. A spell of illness begins with the first day a Medicare Part A beneficiary benefits is provided inpatient hospital services or extended care services and ends on the sixtieth consecutive day in which the patient is neither hospitalized nor an inpatient in a skilled nursing facility. Social Security Act, §1861(a). The chronically ill patients served by long term care hospitals typically exhaust their Medicare coverage. This is in part the reason why the average length of stay of long term hospitals exceeds twenty-five days. Often times patients come to long term care hospitals only after having experienced recurrent hospitalizations in PPS hospitals during the same "spell of illness". As a result, these patients often have exhausted or greatly reduced the number of Medicare covered days available to them prior to admission to a long term hospital. Patients who do not have Medigap coverage and who exhaust their Medicare coverage must "spend-down" their assets in order to qualify for Medicaid coverage. However, Medicaid coverage varies greatly from state to state. Some states have extremely short Medicaid day limits for hospital stays. At least one state provides no hospital coverage for patients (sick, elderly and SSI) who exhaust their Medicare hospitalization benefits. These hospital limits may be adequate for the younger Medicaid populations. (The Medicaid Program typically covers families on aid to families with dependent children.) However, these limits are grossly inadequate for the severely ill elderly population. NALTH believes that the legitimate needs of the Medicare "crossover" population are different than the vast majority of Medicaid recipients who are predominantly young women and children. NALTH believes the elderly population could be adversely affected by a block grant type of program aimed at the AFDC population.

B. NALTH's Suggestion to Finance Removal of the Medicare Day Limit for Most Beneficiaries.

1. The day limit on inpatient hospitalization would not apply to Medicare beneficiaries, except as provided in Number 7, below.

2. All coinsurance and deductibles would remain in effect and be subject to current financing mechanisms, e.g., Medigap, etc.

3. HCFA would annually determine and publish the incremental costs (premium) for beneficiaries to "buy in" to the unlimited hospital Medicare inpatient day coverage.

4. Uniform federal standards for certification of Medicare supplemental policies under Section 1882 of the Act would require that Medigap insurance separately price components of offered supplementary insurance so that Medicare eligible individuals are able to compare, on a timely basis, the price of purchasing insurance for supplemental inpatient hospital benefits from a Medigap insurer or from the Medicare program.

5. Medicare-eligible persons with resources who purchase unlimited Medicare hospital coverage would choose between the government and Medigap plans. Where the government price is lower, and the beneficiary elected government coverage, the insurer would be required to grant a full credit for the higher insurance cost when selling the remainder of the Medigap package to the insureds. For example, if the Medigap premium is $300 and the government's "stay in place" insurance costs $15, while private Medigap coverage costs $25, a beneficiary who elected government coverage would pay $275 for Medigap coverage, $15 for "stay in place" coverage Medicare insurance and would save $10.

6. States would maintain effort and "buy in" to the new

Medicare hospital benefit for individuals who would, under current rules be Medicaid eligible.

7. Individuals who could not afford to purchase Medigap or the new federal "buy in" insurance as determined by the Secretary due to the unavailability of resources or income at a specified percentage of, or above the national poverty level, would be entitled to the federal "stay in place" coverage. Individuals who have resources or income which exceed the poverty level established by the Secretary and who voluntarily choose not to purchase Medigap or the federal "buy in" coverage would spend-down until they meet Medicaid eligibility standards and then would be included in the Program.

As noted above, many NALTH member hospitals currently are reimbursed at rates which are significantly below the cost of caring for Medicare beneficiaries. Repeal of the day limit will increase the losses suffered by these hospitals. For this reason NALTH recommends that the repeal of the day limit and selective rebasing of long term care hospitals be enacted together.

The Congressional Budget Office had previously scored the repeal of the day limit in connection with the Medicare Catastrophic Coverage Act. The cost estimate for fiscal year 1992 was $420 million. A copy is attached as Attachment "B". This is approximately $11 - $12 per beneficiary per year. We are unable to determine whether this includes savings which would be realized from the Medicaid program as a result of repeal of the Medicare hospital day limit. The Medicaid program generally pays for additional care for Medicare individuals who exhaust their inpatient hospitalization benefits. These funds could be redirected to pay for the repeal of the day limit.

III. Opposition to Moratorium on New Long Term Hospitals.

NALTH is aware of suggestions by HCFA for a moratorium on new long term hospitals. NALTH believes a moratorium on new long term hospitals is unwarranted and counter-productive. Data available to NALTH indicates that payment on a per diem basis to long term hospitals is less than outlier payments to PPS hospitals. NALTH also believes, but cannot demonstrate that in undeserved areas a spectrum of patients experience repeat PPS admissions from nursing facilities which would not occur if the patient received services in a long term hospital. Also, it should not be forgotten that long term hospitals have programs of care such as rehabilitation for the medically frail patient which may not be duplicated in a PPS hospital setting. The clinical goal for these patients is to regain a health status which does not require continued inpatient care and results in discharge to the patients' homes. Also, classes of patients with specialized program needs such as those with AIDs (who are Medicare eligible due to SSI), the elderly who experience unexpected behavioral changes and require comprehensive medical and psychiatric testing are best served in long term hospitals who specialize in caring for these patients.

NALTH would be pleased to further address these issues should the Committee desire further information.

Sincerely,

Edward D Kalman/DDS

Edward D. Kalman
General Counsel
BEHAR & KALMAN
Six Beacon Street
Boston, MA 02108
(617) 227-7660

EDK:jan
nalth\pdm.let

ATTACHMENT "A"

Proposed Policy for Rebasing Long Term Hospitals

- Participating as a long term hospital
- Has disproportionate share patient percentage of at least 25 percent
- Sustained a Medicare operating loss (after any adjustments) for two immediately preceding cost reporting periods
- Eligible for rebasing using FY 1992 cost report

Rebasing cost estimate should be net of any amounts that would be likely to be recognized through adjustment process, as well as the 50 percent cost-sharing for costs between the target and 120 percent of the target.

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G) Rebase long-term hospitals as described:

	FY94	FY95	FY96	FY97	FY98	TOTAL
Outlays	$4	$5	$5	$5	$6	$25

ATTACHMENT "B"

MEDICARE CAT. COVERAGE ACT

P.L. 100-360

[page 35]

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee states that the letter from the Congressional Budget Office indicates that there is a change in budget authority and that there are no new or increased tax expenditures as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2470.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As ordered reported by the Committee on Ways and Means on May 19, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Direct spending/offsetting receipts:					
Section 101 provisions:					
Eliminating the limit on covered hospital days:					
Budget authority	−10	−30	−60	−90	−130
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15	−50	−95	−150	−210
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20	−60	−110	−160	−220
Outlays	395	630	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10	75	175	290	410
Changing the calculation of the part A premium:					
Budget authority	15	25	25	25	25
Outlays	15	25	25	25	25
Effect on turst fund from change in part A premium:					
Budget authority	−16	−27	−30	−30	−35
Outlays	0	0	0	0	0
Section 102 provisions:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10	−30	−55	−85	−120
Outlays	170	275	315	350	385
Eliminating the prior hospitalization requirement of coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75

STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care is a membership association whose members serve as medical directors in just under 2,000 hospitals nationwide. Our members generally are board certified pulmonologists with a small minority of anesthesiologists. In our capacity as medical directors of respiratory care we are extremely familiar with virtually all aspects of the facet of the Medicare durable medical equipment company (DME) benefit that authorizes coverage and payment for home oxygen. That component of the Medicare program has received a fair amount of attention in recent months, particularly related to a report of the Office of the HHS Inspector General, "Oxygen Concentrator Services."

As background, it is important to emphasize the objective, clinical focus of our comments. We believe that we speak authoritatively on behalf of pulmonary medicine in this country and have provided input time and time again to the OIG and the Health Care Financing Administration on issues related to the DME oxygen benefit. In fact it was our organization that condensed the HCFA Certificate of Medical Necessity for home oxygen (HCFA Form 484) into a workable, well accepted one page check-off form.

It is our understanding that the Congress may be considering, in response to the OIG study, a shift to competitive bidding for oxygen, modeled after the approach of the Department of Veterans Affairs. We strongly urge the Congress not to adopt that approach because we believe it will adversely affect the care Medicare beneficiaries who suffer from chronic obstructive pulmonary disease (COPD) currently receive. We do have an alternative recommendation that will address directly the problem of payment levels for oxygen concentrators and simultaneously, we believe, address other related problems inherent with the current statutory limitations for payment of oxygen.

THE PROBLEM: Simply stated, the current statute is supposed to recognize all oxygen therapy modalities equally. Whether a physician orders a concentrator, a liquid system, or a gaseous system, the supplier receives the same payment. The statute was designed this way to eliminate cost based reimbursement that had rewarded the use of liquid systems. In a short time after the passage of the "six point plan" the use of concentrators shot upward and the use of the more costly liquid systems dropped. There was no clinical reason for this shift. It occurred, regardless of what the physician had prescribed. "We only do concentrators" became a popular refrain of suppliers when queried by physicians or patients who suddenly found the concentrator replacing the previous system.

It does not take a strong background in mathematics to determine that the profit margins for a concentrator are very attractive to suppliers. And, for understandable, **BUT WRONG REASONS**, the VA also noted the relatively low cost of concentrators. The VA began a competitive bidding process for providing their constituency with concentrators, regardless of the medical need of the patient. A single concentrator with a maximum 50 foot tether meets the medical needs of no more than 15 - 20% of the Medicare beneficiary population. We seriously question whether it meets the medical needs of the VA population.

The COPD population is increasingly mobile, thanks to innovations in oxygen delivery systems. A portable oxygen system that allows the COPD patient to leave his/her house and visit friends, do grocery shopping, and numerous other activities of daily living outside the home is an integral part of the Medicare home oxygen benefit. Not so with the VA. The typical VA contract that we are familiar with, again, meets the medical needs of a very small portion of the truly homebound, probably bed bound COPD population.

Furthermore, a strong inference of the OIG report focuses on sheer overutilization of oxygen therapy. NAMDRC pushed HCFA to adopt specific objective medical criteria for a Medicare beneficiary, documented on the Certificate of Medical Necessity, in order for oxygen to be a covered supply. The criteria are well documented in the medical literature. Therefore, overutilization can occur only when fraudulent 484s are submitted by a supplier, and all parties to such a fraudulent submission, including physicians, should be prosecuted vigorously.

While there may be a tendency to note the significantly higher rates of oxygen consumption in the United States as compared to other countries, we would cite the following: "Patients who qualify for long term oxygen therapy are being identified earlier before advanced stages of lung disease occur. There is greater awareness of the indications for long term oxygen therapy among physicians and allied health professionals and a wide availability of suppliers to provide the service and equipment. Mechanisms for reimbursement are readily available for most patients who qualify for home oxygen therapy.

Since the indications for long term oxygen therapy and requirements for reimbursement have been well defined in the United States, it is increasingly unlikely that home oxygen therapy is prescribed unnecessarily, and more patients who would benefit from oxygen therapy are able to receive it. Failure to identify patients who might qualify for therapy and the lack of financial resources, equipment and suppliers are reasons for less use of home oxygen therapy in many other countries."[1]

NAMDRC fully acknowledges there is little question regarding Medicare payment for concentrators. It is too high. With the actual acquisition cost to a supplier for a concentrator in the $800 - $1100 range, the current monthly payment is inflated. Liquid systems, on the other hand, are less attractive to suppliers because of higher maintenance/service costs. Regardless of the clinical appropriateness, concentrators are the modality of choice for many suppliers, a decision driven by dollars, not medical appropriateness.

THE SOLUTION: As much as we believe that the Medicare program has absorbed an inordinate portion of cuts the past 15 years as the Congress has reckoned with budget matters, it seems truly fruitless to attempt to convince Congress to find other sources of cuts. We genuinely believe that we have absorbed more than our fair share of cuts since 1981 and believe that additional cuts, regardless of the political popularity, eventually reduce the care, the quality and access of Medicare beneficiaries.

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[1] O'Donohue WJ. Jr., Plummer AL Magnitude of Use and Cost of Home Oxygen Therapy in the United States, Chest 1995; 107: 301-302

So, for the sake of discussion, let's assume that the Congress, in its infinite wisdom, reduces all oxygen payments 3%. Based on current law, that still leaves a definable pot of money for home oxygen therapy. We believe that pot of money ought to be redistributed *within the various oxygen modalities*, reducing payments for concentrators and raising payments for liquid systems, *maintaining budget neutrality based upon the reduced pot of money.* Because concentrators account for the vast majority of the Medicare home oxygen therapy benefit (see attached data from HCFA), a 20% reduction in concentrator payments can be used to boost liquid payments approximately 50%. Our rationale for this approach is both medically and fiscally sound. Based upon preliminary conversations with the Health Care Financing Administration, together we believe that this is a workable cost saving solution.

One important issue raised by the OIG study, however, should be addressed by the Congress, particularly if the Congress is serious about saving money while continuing to provide home oxygen therapy for approximately 500,000 Medicare beneficiaries. That issue is the question of service and the total absence of standards in the area of home oxygen therapy. Congress must mandate appropriate standards for suppliers to assure that a supplier complies with the specific modality of oxygen cited on a physician prescription. As with any prospective payment system, there must be safeguards to assure that appropriate services and equipment are being provided. Furthermore, service standards for concentrators, correlated with the technology of warning systems, should be mandated by the Congress and directly tied to payment.

For 1993 HCFA paid (i.e., allowed charges) the following amounts of oxygen:

Stationary-Rental-Gaseous O_2-1 unit = 50 cu. ft.	$	15,319,055
Stationary-Purchase-Gaseous O_2		16,361
Portable-Purchase-Gaseous O_2		5,411,404
Portable-Rental-Gaseous O_2		80,707,053
Portable-Rental-Liquid O_2		28,358,944
Portable-Purchase-Liquid O_2		253,487
Stationary-Rental-Liquid O_2-1 unit = 10 lbs.		170,081,107
Stationary-Purchase-Liquid O_2		46,489
Gaseous O_2-Owned system-1 unit = 50 cu. ft.		608,990
Liquid O_2-Owned system-1 unit = 10 lbs.		755,999
Portable-Gaseous O_2-1 unit = 5 cu. ft.		442,986
Portable Liquid O_2-1 unit = 1 lb.		31,573
O_2 Concentrator-High Humidity-244 cu. ft.		1,927,844
O_2 Concentrator-High Humidity-488 cu. ft.		39,318
O_2 Concentrator-High Humidity-over 1952 cu. ft.		8,974
O_2 Concentrator-$\leq$ 2 L/Min.		269,038,396
O_2 Concentrator-2-3 L/Min.		209,048,031
O_2 Concentrator-3-4 L/Min.		118,447,124
O_2 Concentrator-4-5 L/Min.		214,632,398
O_2 Concentrator-$\geq$ 5 L/Min.		62,821,678
O_2 and H_2O Vapor Enriching with Heater		3,159,829
O_2 and H_2O Vapor Enriching without Heater		3,475,578
TOTAL		$1,169,312,553.00

STATEMENT OF PETER J. FERRARA
SENIOR FELLOW
NATIONAL CENTER FOR POLICY ANALYSIS

Medicare faces an overwhelming financial crisis. The latest annual trustees' report for the Hospital Insurance (HI) portion of the program shows that it will likely fall short of funds to pay promised benefits within 5 or 6 years. Moreover, even before then, rapidly growing annual deficits in the HI program will begin adding large amounts to the total Federal deficit. By 2000, the annual deficit in HI will be over $40 billion, increasing the total Federal deficit by that amount.

The Federal government's general revenue contributions to the Supplementary Medical Insurance (SMI) portion of the program will also have to soar rapidly in order to pay all promised benefits. By 2000, the annual general revenue contribution to SMI will climb to about $100 billion. Counting this along with the deficit in HI, Medicare will be adding almost $150 billion to the total Federal deficit in 2000, about three-fourths of the total Federal deficit today.

Over the long run, the financial gaps in Medicare just grow ever wider. By the time those entering the work force today retire, payroll tax revenues under the government's intermediate projections will be sufficient to pay only about 30% of promised HI benefits. Paying all promised benefits to these workers would require an increase of over 3 times on the total HI payroll tax rate, from 2.9% today to almost 10% in 2040 and beyond. By comparison, the total payroll tax rate for Social Security, including retirement, survivors, and disability benefits, is 12.4% today.

Under so-called pessimistic projections in the latest annual trustees' report, current payroll tax rates would be sufficient to pay only about 16% of promised HI benefits when today's young workers retire. Paying all promised benefits to these workers would require an increase of almost 7 times in the current HI payroll tax rate, from 2.9% today to 20.26% in 2040. The HI payroll tax rate alone would then be over 50% higher than the total payroll tax rate for Social Security today.

The general revenue financing burden for SMI would similarly skyrocket. By the time today's young workers retire, this annual contribution would be $340 billion to $485 billion in constant 1995 dollars, under the intermediate to pessimistic projections.

Moreover, financing all promised Medicare benefits would require an equivalent increase in the monthly premiums paid by the elderly for SMI. Under the intermediate assumptions, by the time today's young workers retire, premiums in constant U.S. dollars would have to increase more than 9 times over today's level. Even if we account for higher incomes in the future, the premiums would have to be more than 4 times as large relative to income as today. In other words, the premiums would be of the same relative magnitude to incomes of the future as monthly premiums today of $185 per beneficiary, or $370 dollars per couple, amounting to $2,200 per year per individual, or $4,440 per year per couple.

Under the "pessimistic" projections, premiums would have to increase more than 13 times in constant 1995 dollars by the time today's young workers retire. Or, accounting for higher incomes, the premiums would have to be almost 9 times as large relative to income as today. In other words, the premiums would be at the same relative magnitude to incomes of the future as monthly premiums today of $360 per beneficiary, or $720 per couple, amounting to $4,320 per year per individual or $8,640 per year per couple.

Bad Solutions

Means Testing. Some would attempt to solve these problems by means-testing Medicare. Benefits would then be reduced, or possibly eliminated altogether, as income rises. But such means-testing would effectively constitute a tax on savings, investment and work. Those who save and invest more during working years to have a higher income in retirement would find that higher income causing a reduction in Medicare benefits. Those who work and earn more during retirement years would be similarly penalized. This effective tax burden would result in less savings, investment, work, and economic growth.

Forcing all the reductions on only one small part of the population would also be unfair. In addition, this approach would never produce enough savings to completely solve the long term problems of the program.

HMOs for Medicare. Another approach is to push the elderly into HMOs to receive their Medicare benefits. At a minimum, the elderly would be offered some incentive that would be available only if they choose to receive their Medicare benefits through an HMO. The HMOs would then be expected to produce cost savings for Medicare.

This amounts to a policy to utilize HMOs to effectively ration health care for the elderly. President Clinton's health care reform plan last year attempted to adopt the same policy, which proved to be highly unpopular with the general public. Such rationing is wrong because the government would be restricting the essential freedom of citizens to choose and control their own health care. Any choice of HMOs for Medicare benefits must be on a level playing field with all other options.

Increased Medicare Premiums. About 25% of the costs for SMI, also known as Medicare Part B, come from premiums paid by the elderly. These premiums have already increased to stiff levels, amounting to about $500 per year per retiree, or about $1,000 annually per elderly couple.

Some now propose to raise these premiums two times for higher income retirees. But this is just another way for the government to grab even more money for a failed program, without addressing its fundamental problems. It would discourage savings, work and economic growth the same as described above for means testing. It would also again unfairly force the burden on just one small group. Nor could this approach ever remotely produce enough revenue to solve the program's problems. Indeed, the premiums under current policy would already grow to unmanageable levels for the elderly, as described above.

In the late 1980's, the government increased Medicare premiums mostly for the higher income elderly to fund new catastrophic benefits under the program. The elderly responded with a political firestorm that forced repeal of the taxes and the benefits. What will the elderly say when the premiums are similarly raised, but without the new benefits?

A Proposal for Reform. There is a better way. Medicare benefits can be reformed to ensure that the program spends no more than the amount of revenue coming in each year. Moreover, the program's revenues can be reformed to ensure that they impose no more than a reasonable manageable burden.

The first component of such reform would be a commitment to hold the Medicare payroll tax to its current rate of 2.9%, without any increases to address the program's long term financial deficit. The payroll tax is already far too high, excessively burdening employment with a discouraging levy.

Along with this, the annual general revenue contribution to Medicare Part B would be capped to grow no faster than the rate of economic growth. The monthly Medicare premiums for the elderly would also be capped to grow no faster than income growth. This would ensure that Medicare financing would not become a greater relative burden over time.

The Medicare benefit structure would then be changed by adding a front end deductible automatically adjusted each year to be large enough to equalize expenditures with the program's revenues. Beneficiaries would have to bear initial expenditures each year up to this deductible amount before receiving any Medicare benefits. Retirees could pay for such expenses directly, or purchase private insurance to cover some or all of the added deductible.

This deductible amount would start small and grow slowly over time, perhaps amounting to a few hundred dollars after the first 10 years or so. By the time today's young workers retired, the amount would likely have grown to a few thousand dollars per year in today's terms. But these workers would have many years to prepare for this development, through increased IRA savings, for example, or other means of providing for additional retirement income.

The key to this proposal is to recognize that Medicare revenues and benefits would still increase in real terms at the rate of real economic growth over time. They would just grow no faster than such real growth. Surely, given the persistent Federal deficit, and the overwhelming long term Medicare financial crisis, we cannot increase benefits even faster than that. If the economy grows faster, or health costs grow more slowly, the added deductible would automatically grow more slowly over time.

Several additional features would make such reform more appealing. IRAs should be expanded so that long term savings to pay for the added deductible would be more feasible. Vouchers could be provided to the poor sufficient to enable them to purchase private insurance to cover the added deductible. Medicare benefits could be provided without the current limits that leave the elderly exposed to the most catastrophic expenses. This would cost very little overall, but would allow the elderly to focus on financing only the more routine front-end expenses. If the Medicare retirement age were expanded slowly over time to age 70, then the amount of the increased deductible would be substantially reduced. In addition, under the reform, the elderly would avoid the burden of higher Medicare premiums relative to income over time.

Perhaps most importantly, the elderly should be allowed to take their per capita share of Medicare funds and use it to contribute to a Medical Savings Account combined with high deductible catastrophic insurance, or buy any other private insurance or HMO coverage of their choice. This would allow the elderly to each choose the benefits and other features they prefer. The cost control incentives of MSAs would substantially reduce

Medicare expenses over time, reducing the level of the added front-end deductible. Moreover, through this option, the elderly could escape the rationing and reduced quality of care that is increasingly being imposed on them under Medicare.

Under this reform, Medicare would add no more to the Federal deficit in the future than today, because future benefit growth would be tied to revenue growth. Indeed, the reform would produce enormous budget savings over time. Remarkably, the long-term Medicare financing crisis would be solved as well, as Medicare would spend no more each year than it takes in. Over time, Medicare would be reformed into a more rational program protecting the elderly against high medical expenses, but not attempting to pay for all routine expenses. In addition, the higher deductibles and MSAs are the best possible means of controlling rising health costs under Medicare.

Such reform would admittedly be highly controversial politically. But in the context of the Federal deficit and the overwhelming long term Medicare financial crisis that requires fundamental reform, in any event, this proposal is the best of the alternatives, politically as well as economically. It protects workers from increased taxes while still allowing real benefits to grow with the economy, and providing maximum freedom of choice, and other important highly appealing advantages for the elderly. Opponents would have to argue that taxes must be increased so that real benefits can grow more rapidly than the economy, not a generally appealing proposition.

National Committee to
Preserve Social Security
and Medicare

Statement of

The National Committee to Preserve Social Security and Medicare

The National Committee to Preserve Social Security and Medicare, a grassroots education and advocacy organization representing millions of senior Americans, submits this statement for The Subcommittee on Health of the Ways and Means Committee hearing on the subject of "Controlling Growth in Medicare Costs" and "Medicare Reform and Innovation." The National Committee's mission is to protect, preserve, promote and ensure the financial security, health, and the well being of maturing Americans of current and future generations.

Before Medicare, health care for a retired or disabled person depended on individual wealth or the generosity of family, friends, physicians or local health care institutions. When this wealth and generosity were not available, retired and disabled people often went without care when they needed it most.

Medicare has enhanced life for millions of Americans and their families. While increasing productive years of life for beneficiaries, Medicare has also helped support the development of health care facilities and medical education. In the years since 1966, when Medicare was implemented, much has been learned about reversing life-threatening illness, relieving pain and recovering lost functional capacity. Americans of all ages and degrees of health are benefitting from this program, because it protects whole families from much of the cost of acute health care for senior or disabled family members.

Medicare is working very well. To access to quality care and choice of provider, "Do no harm!" should be the guiding principle as we consider possible Medicare "reforms". Citizens want prudent spending but we also want the insurance we pay for to be in place when we need it. In general, large systems require continuous evaluation and refinement, and Medicare is no exception. "Innovations" may be found that will increase efficiency, hold down cost and eliminate waste, but let us not jump at just any strategy that is advertised as cutting cost. We must ask "whose cost is being cut?" and "who benefits from these cuts?" Will Medicare really pay out less? Will individual beneficiaries get less choice, coverage and quality of care?

In seeking ways to improve Medicare this nation must always keep the individual beneficiary in focus. Medicare's 36 million beneficiaries are overwhelmingly satisfied with this insurance which assures portability, renewability, wide choice of providers, does not exclude preexisting conditions, does not change the ground rules of coverage when people are sick and need care and gives the individual standing to dispute decisions about coverage. Some of the changes being promoted as Medicare reforms would diminish these protections.

Preserve the integrity of the system

Subsidies for low income beneficiaries make sense, but income-based premiums do not. Medicare is not a welfare program. The general fund, which partially subsidizes Part B, has already been progressively financed by individual income taxes. Beneficiaries pay a premium in addition. If premiums are to be income-based, the value of the insurance will undoubtedly diminish in the public eye and Medicare may lose its broad support.

We should avoid new co-pays that will involve new administrative costs and erect further barriers to seeking needed medical care. Medicare beneficiaries already pay much of their health care out-of-pocket and existing co-pays keep some from getting care. If new co-pays are imposed, fewer low income people will seek care and medigap premiums will increase. Please look instead at the prices of services, and ask what a fair price should be.

Control inflation in private sector health care

Increased Medicare expenditures reflect the desired outcomes of the program: longer lives and more beneficiaries. But they also reflect the inflation in private sector expenditures driven by entrepreneurial pricing of services. Medicare accounts for only 17% of the nation's health care expenditures, but is serving the populations that need the most health care. Medicare may pay less than private insurers because of its large volume of claims and careful reimbursement policies, but prices in the private market are continually driving up charges.

If private sector health care inflation can be checked, Medicare will be able to serve its beneficiaries more economically and other people will be better able to afford private insurance. Many complicating factors can interfere. One new concern is that mergers of health care corporations may place monopolistic control of provider rates in the hands of a few companies. Anti-trust action is needed to prevent this.

Health care consumers do not have the expertise to judge their own health care requirements and the relative risks of cost saving choices. Health care is not a typical market commodity because it involves specialized knowledge beyond that of most consumers. Often medical care is not optional because basic survival is at stake and as a result people do not have the luxury of shopping around for care. Citizens need the protection of some basic cost and quality controls, as they do with necessary utilities.

Reduce cost within the Medicare program

Controlling fraud can save much more than it costs. Strategies to reduce fraud have been developed by the HHS Office of the Inspector General (OIG), and strides are constantly being made, with a reported $80 savings for every dollar invested. The Semi-annual Report of the Inspector General April 1, 1994 to September 30, 1994 lists hundreds of millions of dollars of unnecessary Medicare expenditures, including an estimated $85 million that private insurers should have paid, and an estimated $47 million paid for physical therapy that was not medically necessary. However, greater funding is needed for more OIG investigations as well as routine audits to compare services or equipment billed with those received, to examine excessive utilization of services, variations in quality, and unreasonable pricing. Carriers and intermediaries must be held responsible for much of this. We hope that unwarranted charges for supplies now are more likely to be intercepted with reimbursement authority consolidated in four regional carriers, but inconsistencies and abuses are still a problem. Providers and health care professionals should also be expected to report questions of inappropriate pricing, and billing.

Other suggestions for Medicare Savings

Merging Medicare Part A and Medicare Part B could reduce administrative costs and perhaps eliminate double charges. Part B billing for services and supplies that should be covered by Part A reimbursement should be examined in nursing homes certified under Medicare and Medicaid.

Continuous evaluation of pricing of services is needed to appropriately control Medicare reimbursement rates for providers. Particularly in the areas where reimbursements are cost based.

Stricter criteria for utilization of covered services may be needed and justification required for frequency of visits. Medicare subsidies for institutional capital investments and professional education should be reevaluated.

Skilled Nursing Facility (SNF) increased utilization and growing exceptions to the SNF cost limits should be evaluated in light of the care actually delivered. Where exceptions are warranted, a mechanism is needed to assure reimbursements are appropriately used for direct patient care. If prospective payment is instituted for Skilled Nursing Facilities this mechanism will also be needed. Transferring patients from hospitals to nursing homes to save Medicare dollars is not justified unless the care provided is excellent.

Hospital out-patient increased utilization is the area of greatest growth in Part B expenditures. This is an area requiring greater scrutiny. Medicare's basis for reimbursment should be reevaluated and beneficiary co-payments should be based on Medicare reimbursments, rather than the hospital charges.

Home Health Agency growth in utilization and Medicare expenditures should be evaluated. More acutely ill patients are being cared for at home to save hospital costs. This health care market is an area of greatly increased entrepreneurial activity. Quality of care, acceptability to beneficiaries and family caregivers and pricing of services should be examined.

"Managed care" for Medicare beneficiaries

Managed care companies prosper by enrolling healthier and younger people, emphasizing preventive care, and limiting utilization of acute care services. They have little experience in caring for the populations that need most acute and post-acute care - older seniors and the disabled.

Medicare savings anticipated by managed care may be exaggerated. Currently Medicare does not save money according to recent evaluations. Some adjustment to the reimbursement rates may change that but might also reduce the incentive for HMOs to sign up Medicare beneficiaries. It is hard to compete with Medicare which pays providers less than most HMOs.

Managed care options should be made available to Medicare beneficiaries who might want them for greater benefits or lower out-of-pocket cost, as long as federal standards, safeguards and appeals rights are assured. There should also be an assured option for seeking care outside the plan when special expertise is needed to treat a life or occupational threatening situation. Perhaps Medicare could establish a financing pool for covering this.

Beneficiaries should not be required to join managed care plans. Medicare's pre-payment for care per person is based on average costs in a geographic area. How can a managed care plan survive under such an financial arrangement other than by limiting needed services to the more costly patients? Elderly, frail people should not be subjected to prolongued waiting for services. They should not have to give up Medicare full acute care, Skilled Nursing Facility or Home Health coverage because they joined a managed care plan. Reportedly some HMOs set arbitrary limits on days of service, that significantly cut needed rehabilitation services that are well justified under Medicare's criteria.

If beneficiaries are going to be involved in managed care programs the plans must be required to meet federal standards of access, structural components, quality of care, patient information and marketing.

Information about all providers in a plan must be given to prospective enrollees, including in-patient and out-patient institutional facilities, primary and specialist physicians and other health care professionals. A beneficiary should have the option to choose a plan that serves his special needs (a person with diabetes should be able to choose a plan with diabetes experts; a heart patient might want a plan with experienced cardiologists and heart surgeons). Also, prompt notice to beneficiaries of changes in participating providers must be given in advance of a provider's change of status or leaving a plan.

Information about geographic location and hours of availability of all provider institutions, emergency facilities, participating physicians and other health care professionals must be made clear.

Information about out-of-pocket costs must be clearly spelled out to prospective and new enrollees as well as information about a plan's procedures and policies for holding down costs (e.g., incentives for physicians re limiting utilization, referrals to specialists, tests) must be explained to beneficiaries.

Choice of primary provider and the ability to change primary providers must be assured.

Provision must be assured for retirees to be able to receive care in different parts of the country, as many retirees change residence with the seasons.

Grievance and appeals processes must assure review within a few hours for denials of requested urgent care. Information about how to use grievance and appeals steps must be provided to all enrollees. Access to HHS hearings and federal court review appeals must be assured for Medicare beneficiaries.

Medicare Select, a lower-cost Medigap program, was designed to increase participation in managed care. Enrollees in this 15 state demonstration program agree to receive care within preferred provider networks. They may use other Medicare providers, but sacrifice Medigap coverage when they do. Medicare Select preferred provider networks are not governed by federal standards and appeal rights that offer some protection to Medicare beneficiaries in other managed care arrangements. It would be adviseable to require federal protections of beneficiaries as required with other managed care arrangements. Safe harbor legislation has allowed discount deals waiving collection of co-payments. It is not clear that care is being managed in any way that cuts Medicare expenditures. Medicare Select providers should also bear some risk if beneficiaries are dissatisfied and want to enroll in a traditional Medigap plan. Congressman Stark's proposed Medicare Beneficiary Protection Act of 1995 will institute needed protections in the Medicare Select program and wisely extend the demonstration period to permit further evaluation. It also strengthens protections for Medicare beneficiaries in other managed care options.

The National Committee supports all efforts to assure the solvency and integrity of Medicare to best serve beneficiaries.

We are concerned that in the rush to transform and restructure Medicare senior citizens will wind up with less choice and higher costs. In the future, further expansion of Medicare coverage will be needed as new knowledge and technology improves health care capability. Eventually, Medicare coverage should include an out-patient prescription drug benefit and certain preventive screening measures.

STATEMENT TO THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Subject: Hearing held on February 7th on Medicare premiums

Person submitting statement
Gerald S. Parker
11 Shore Acre Drive
Old Greenwich, CT 06870

Capacity
Retired citizen, age 78, with 30 years experience in health insurance management with The Guardian Life Insurance Company of America

Representing
Himself only

The objective of the hearings should be to reduce the rate of growth of the cost of Medicare to the taxpayers. The need to do this does not seem to penetrate the consciousness of the several organizations purporting to represent senior citizens. However, all seniors are not ignorant of the need to avoid bankrupting the country.

One obvious place to start is the Part B deductible. Raising that is, in effect, increasing the premium. It must be close to 15 years since it was raised to $100 from the $50 that had then been in effect since 1966. It should be raised to $200 or $300 now and probably indexed every few years thereafter.

With respect to Part A, it's already indexed annually, and I see no benefit pattern modification that would be helpful in saving money and practical to administer. That leaves means testing.

The professional advocates for the elderly keep trumpeting the fallacy that " You paid for these benefits and earned them. Don't let the Congress take them away from you." To be fair, much of the blame for that misunderstanding lies at the door of Congress, which made that sort of assertion for years in its determination to capture the elderly vote. But it was never true, never intended to be true, and is now a complete falsehood of which the organized advocates should be ashamed. I am sure they know the truth!

It seems to me that a reasonable approach would be to make a charge, deductible from Social Security monthly pension benefits, to people who can afford it. It could be levied on taxable incomes of, for example, $50,000 or more and perhaps graded up somewhat for those with taxable incomes exceeding $100,000, $150,000 and $200,000. Charges could be made for Part A, and perhaps for Part B also if it is needed. And at that level, impoverished elderly and the lower income half of the "middle class" would escape most of it. If taxable incomes would be too difficult to keep track of, adjusted gross incomes could be used, beginning at somewhat higher levels.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

Statement: Contract With America
Sub-Commitee on Health
Hearings on the " Medicare Reform "
February 10, 1995

Mr. Chairman and Honorable members of this Committee:

We respectfully request to have the following testimony introduced in the written record for the February 10m 1995 Medicare Reform hearing.

This testimony, which was presented to the Sub-Committee on Welfare of the Ways and Means Committee during the February 2, 1995 hearings on Welfare Reform, are our our views regarding what should be the impact of the Contract with America on Medicare for Puerto Rico.

As a physician, I have devoted my medical career to give medical services to the needy in Puerto Rico as an Ob-Gyn for the Health Department. The great majority of my patients are poor people, whose incomes fall below the poverty line, and whose means of support come from welfare programs. These 26 years have given me the opportunity to feel first hand the needs of the people who will be affected by the proposals in the Contract with America.

- **But, you are right ! ....The American Welfare system is broken.**

Puerto Rico endures the same sad story as every other state. It is sad that $14.6 billion dollars in federal funding and tax credits have not markedly changed the quality of life for those it intended to.

Federal programs have created a welfare culture in major United States cities. These have held hostage generations of families in a web of overlapping federal handouts which promote dependency, illegitimacy, unemployment and anti-ethical values.

The hopes of many are with this new Congress. We encourage you to practice radical surgery to stop the billion dollar hemorrhage of federal funds throughout the Nation. State and territorial governments are hammered by the myriad of bureaucratic rules for over 300 federal assistance programs. What a waste ! It would be vastly more efficient to consolidate these into five or seven block-grants with clear guidelines.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

Remember the conservative revolution of the Reagan years, with the President's "state's rights agenda" ? This Congress should learn from the block grant that replaced the Food Stamp Program. It was the outcome of the Reagan conservative agenda.

The block-grant did not work because it was the only assistance program. Partial welfare reform, without the extension of all other programs, failed to give Puerto Rico the edge to produce the shining results of President Reagan's vision of empowering local government. We endorse block grants, but with clear federal guidelines

In order to eradicate the conditions which trap welfare recipients in a state of cultural and economic poverty, we urge Congress to establish clear guidelines to expand the JOBS programs, and to limit cash benefits to a specific number of years. We support the creation of empowerment or enterprise zones to help our major cities generate more jobs.

We support a complete restructuring of the American Welfare system. Put in place a system that promotes work, education, self sufficiency and family values in all the Nation. including Puerto Rico. Include the 3.6 million United States citizens in Puerto Rico, because we suffer doubly under the ill-focused federal assistance programs that are underfinanced.

- **The Federal "Safety Net "for United States citizens in Puerto Rico is incomplete.**

Unequal federal funding limits the benefits of former President Reagan's "Safety Net" for United States citizens, as more than 200,000 senior Americans in Puerto Rico live in substandard conditions. Congress established the Supplemental Security Income program (SSI) in 1972 to guarantee a minimum level of income to needy aged, blind, and disabled persons, which should include all U.S. citizens, and exclude aliens without established legal residence.

However Congress did not expand SSI to Puerto Rico, since the program is funded from the general US Treasury Fund and we do not pay full Federal Taxes. In contrast, we qualify for all other Social Security entitlements, as we have been paying Social Security contributions.

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

We urge Congress to rectify this unequal treatment, and to finance the extension of the Supplemental Security Income by extending the Federal Income Tax to Puerto Rico, and phasing out the archaic practice of "cover overs" of Federal custom duties and excise taxes to the Puerto Rico Treasury.

- **We are ready to assume equal responsibilities**.

The United States citizens in Puerto Rico are ready to assume increased responsibilities. We already contribute **$2.2 billion** in Social Security taxes. We should not be treated different than the residents in any other states. In addition to unequal treatment under the Supplemental Security Income, the United States citizens in Puerto Rico are treated unequally in the Medicaid, Medicare, Aid to Families with Dependent Children and Food Stamp programs.

We want equal treatment through the Contract Proposal Welfare Reform, re-focusing our goals on self - sufficiency, work fare and family values.

WE PROPOSE THAT CONGRESS:

1. **Gradually extend the federal tax system to Puerto Rico over a 5 year period, while during the same time, phase in all federal programs, in order to shift some of the burden of operating our great Nation to the United States citizens in Puerto Rico.**

2. **Phase out the cover- overs of Federal custom duties, fees, and excise taxes and the Possessions Tax Credit over a five (5) year period.**

3. **Establish economic incentives such as President Reagan's Enterprise zones to help reduce unemployment in all affected areas. (Empowerment zones.)**

Miriam J.Ramirez de Ferrer MD
President, Puerto Ricans in Civic Action

THE UNITED STATES WILL BENEFIT FROM THE POSITIVE EFFECTS OF EXTENDING THE FEDERAL INCOME TAX SYSTEM TO PUERTO RICO.

1. It will help to balance the budget:

With the proposal for a Balanced Budget Amendment, the U.S. taxpayer will find some relief when we share the fiscal burdens through our contributions. As it stands presently, there is no relief in sight for the US taxpayer, but with the Contract with America, all U.S. citizens can help carry the load and realize the benefits of a sound fiscal future.

According to the Congressional Budget Office, extending the federal tax code to Puerto Rico would result in more than **$2 billion** in annual federal revenues. Additionally, the complete phase out of Section 936 tax credit would produce and additional **$2 billion**, according to the latest tax expenditure estimates of the Joint Committee on Taxation. This would result in a total of approximately **$4 billion** annually.

The next table shows the amount of federal revenues that will be collected in Puerto Rico in the years 1999 and 2000, after the extension of the federal tax system:

	1999	2000
Total change in Federal revenues from Puerto Rico sources (**millions**)	$2,251	$2,244
New excise taxes	$395	$414
Custom duties	103	171
Rum excise tax	265	268
Individual income tax	809	846
Tax on Puerto Rico Corporations	519	545

(Source: Congressional Budget Office, April 1990)

2. Working families in Puerto Rico, who earn mostly wages would pay lower federal income taxes than their current local tax burden.

The Puerto Rico taxpayer pays more state income tax than their fellow citizens in most of the other States of the Union. We are not equally treated in the U.S. Budget, so the government of Puerto Rico must levy high local income taxes in order to give services to the people.

Since federal income tax has not been extended to Puerto Rico, the middle class will not benefit from those changes to the tax return proposed by the Contract with America. The extension of the federal income tax system will allow our working families to enjoy the benefits of higher tax credits for children, personal exemptions, and lower tax rates. The Contract's capital gains tax cut would also help spur investments and the economy in the island.

It would also allow Congress to extend the Family Reinforcement Act provisions in the Contract with America to Puerto Rico.

3. Thousands of high income individuals who now escape taxes legally through tax loopholes in the local tax system would have to pay federal income taxes.

For example, interest on mortgage backed securities, known as Ginnie Maes, and interest on U.S. Treasury bonds are exempted from local income tax, but not federal income tax. Investors in Puerto Rico earned about $100 million in interest income on these instruments, and nearly $1 billion in manufacturing and tourist enterprises which receive partial tax exemption under local income tax laws.

4. United States taxpayers will be pleased to know that all who benefit from the United States budget, will have to pay their share. " If you play, you pay."

5. Puerto Rico's "burden sharing" will restore the dignity of the United States citizens in Puerto Rico.

6. It would bring justice to the hard working families who live on wages which are subject to withholding source and who carry the burden of paying for the Puerto Rico budget.

The burden will be shared by all, as the Internal Revenue Service extends its enforcement power and uncovers the extensive underground economy in Puerto Rico. As loyal American citizens, people will recognize the importance of filing returns. (Read: Federal liability)

7. Both the Governor of Puerto Rico, Dr.Pedro Rossello and the Resident Commissioner, Carlos Romero Barcelo Esq., have publicly endorsed this concept. (See newspaper clipping)

President Reagan's state's rights conservative agenda got its start in a model block-grant program to Puerto Rico; let's complete the Reagan revolution with full application of the provisions of the Contract with America in Puerto Rico.

POSITION PAPER OF
HONORABLE CARMEN L. FELICIANO DE MELECIO
SECRETARY OF HEALTH
OF THE COMMONWEALTH OF PUERTO RICO
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS

INTRODUCTION

Health care is the second largest service sector within the Puerto Rican economy, the first being education services. The salary contribution generated by this sector amounted to $359.6 million in 1993. The health care industry comprises over 25% of the jobs and compensation of the service sector. During 1992, the health care industry accounted for 41,460 jobs in the hospital sector, or 70% of the labor force of this industry. Furthermore, this sector represents about 20% of the labor force of the entire Puerto Rican service industry.

During 1991, the federal minimum wage went into effect in the health care industry. In addition, the local mandatory decree applicable to the professional services industry raised the minimum wage to $5.00 per hour. These changes had a significant impact on the health care industry costs and is evidence of the industry's vulnerability to all changes, including changes in federal regulations as well as in other economic variables.

In conclusion, the health care industry - and especially the hospitals - have two important roles in the local economy. First, the industry generates a significant number of jobs. Secondly, it fulfills its fundamental role of promoting and maintaining the health of the Puerto Rican population.

HOSPITAL FACILITIES

Puerto Rico has 77 licensed hospitals, of which 30 are public and 47 are private. Private hospitals include profit and not-for-profit institutions. Two of the private hospitals are currently closed.

For the period of October 1, 1991, through September 30, 1992, there were 384,345 patient admissions of which 243,244 were within the private institutions. During the same period, the private hospitals generated 50 admissions per bed, while the public sector generated 46. These figures indicate the importance of private hospitals to the Puerto Rico health care system.

FEDERAL PARTICIPATION

Puerto Rico has a special relationship with the United States concerning federal assistance, especially in respect to the Medicare and Medicaid programs. *In the case of Medicaid, Puerto Rico has the third largest Medicaid-eligible population because of its poverty level, yet it receives the lowest percentage of federal contributions.* This situation has placed a tremendous burden on the local government which is responsible for providing adequate care to the indigent population.

With regard to Medicare, Puerto Rico entered the Prospective Payment System in 1987, following lobbying efforts by the Puerto Rico Hospital Association and the government of Puerto Rico. Upon approval by Congress of the Prospective Payment System for Puerto Rico, a special formula was designed by Congress that provided a standardized amount determined as follows: 75% of the Puerto Rico hospitals historic average cost per discharge and 25% national average.

This formula was fixed from the beginning, unlike U. S. hospitals which went through a three year transition before reaching the 100% national rate. At the time, the Hospital Association and the health care community called attention to the unfairness of the proposition. Furthermore, *the formula has been challenged not only on the basis of its unfairness, but on the basis that it does not accurately reflect the cost structure of hospitals in Puerto Rico,* especially when confronted with public hospitals costs.

INACCURATE PPS BASE YEAR

One of the main concerns is that *the base year selected for the formula did not accurately reflect hospitals' costs for various reasons,* among which are:

1. *Public hospitals failed to recognize all costs.* Examples of these are ownership and indirect costs, which were mostly omitted.
2. *Lack of a uniform charge structure* automatically deprived the public hospitals of 2% of their allowable costs, thus understating the costs used in determining the Puerto Rico Component.
3. *The labor component was determined from totally inadequate data* in which many contracted services were missing. In addition, labor rates were significantly lower because the minimum wage had not gone into effect in the health care industry until 1991.

In general, *the formula has built-in inequities whereby a hospital with a high salary structure is penalized, while a hospital with a low salary structure is rewarded.* This created poor incentives for the low salary structure hospital to increase salaries.

It is obvious that the information upon which the formula was constructed is inaccurate. This is evidenced by the fact that *the non-labor component of the DRG's formula is about 50% for Puerto Rico when compared to other regions in the United States.*

REGIONAL AND PUERTO RICO ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NON LABOR

	Large urban areas		Other urban areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
New England	$2,840.62	$1,137.84	$2,795.63	$1,119.82
Middle Atlantic	2,592.46	1,038.44	2,551.42	1,022.00
South Atlantic	2,654.29	1,063.21	2,612.28	1,046.38
East North Central	2,892.31	1,158.55	2,846.52	1,140.20
East South Central	2,508.24	1,004.71	2,468.53	988.80
West North Central	2,711.20	1,085.99	2,668.26	1,068.80
West South Central	2,638.83	1,057.01	2,597.06	1,040.27
Mountain	2,621.88	1,050.22	2,580.37	1,033.59
Pacific	2,680.57	1,073.72	2,638.13	1,056.73
National	2,682.96	1,074.69	2,682.96	1,074.69
Puerto Rico	**2,416.27**	**503.53**	**2,378.02**	**495.56**

Puerto Rico is an island. Therefore, most of its products are imported from the U.S. mainland, which represents a tremendous source of business for U.S. enterprises. All items imported into Puerto Rico, with a few exemptions, are taxed from 6.6% up to 19%. In addition, overseas freight and incidental shipping and handling costs are significant. Consequently, it would be erroneous to assume that Puerto Rico's cost of materials, supplies and equipment to be equal or lower than similar costs in the mainland. Therefore, it would be impossible for the nonlabor related costs to be 50% lower.

PR WAGE INDEX COMPARED TO OTHER STATES

Arecibo, lowest in PR	.3798
Aguadilla, Highest in PR	.4758
Caguas	.4373
Ponce	.4518
San Juan	.4367
Mayagüez	.4533
Mississippi, lowest in US	.6577
California, Highest in US	1.4658

Another problem with the formula is the wage index applied to Puerto Rico. Puerto Rico's wage index ranges from .3798 to .4758. *If we compare Aguadilla's, Puerto Rico wage index (.4758), which is the island's highest, to Hattiesburg, Mississippi's wage index (.6577), which is the lowest in the U.S. mainland, we can observe a difference of .1819 or 38%.* If we also compare Aguadilla's wage index (.4758), with Oakland, California's wage index of 1.4658, which is the highest in the United States, we observe a difference of .99 or 208%.

FEDERAL CAPITAL PAYMENTS

We also need to emphasize another major difference between Puerto Rico and the rest of the states in regard to the payment methodology, specifically, the federal capital payments. This payment is computed by taking the DRG Relative weight multiplied by the Federal Capital rate. This factor is then multiplied by the Federal portion of Capital rate times the Geographic adjustment factor times the Large urban add-on (this last factor does not apply to Puerto Rico, at present). *The following are the major problems with the formula:*

1. The federal capital rate for Puerto Rico is $289.87 which, when compared to the national rate of $376.83, *represents a lower rate of $86.96 or 30%.*
2. The geographic adjustment factor (GAF) in Puerto Rico ranges from .5153 to .6013 as shown in following table. *These GAFs are substantially lower than that of next lowest geographic area defined by HCFA, which is Mississippi at .7506, which represents a difference of 25%.*

Geographic Adjustment Factor

Aguadilla, highest in PR	.6013
Arecibo, lowest in PR	.5153
Caguas	.5676
Ponce	.5804
Mayagüez	.5817
San Juan	.5670
Lowest in USA	
Mississippi	.7506
Highest in USA	
California	1.2994

As a result of the foregoing, the hospitals in Puerto Rico individually claim losses in their services to Medicare patients. This is demonstrated by accumulated statistics from the Medicare cost reports of the past several years. Following are some comparative statistics of Puerto Rico public and private hospitals.

GOVERNMENTAL HOSPITALS INPATIENT COST
COMPARED TO MEDICARE PAYMENT RECEIVED
FROM THE YEAR 1988 THROUGH 1992

	1988	1989	1990	1991	1992
Inpatient Cost	$31,085	$44,833	$51,934	$50,840	$53,581
Medicare Payment	$34,910	$55,074	$50,909	$62,547	$62,396

Note: 000's Omitted

PRIVATE HOSPITALS INPATIENT COST
COMPARED TO MEDICARE PAYMENT RECEIVED
FROM THE YEAR 1988 THROUGH 1992

	1988	1989	1990	1991	1992
Inpatient Cost	$84,594	$122,557	$127,875	$154,517	$175,463
Medicare Payments	$102,796	$130,017	$130,943	$153,604	$172,561

Note: 000's Omitted

As shown in the above table, during the period from 1988 through 1992 Medicare inpatient costs increased from $84,594 to $175,463 or about 200%, while Medicare Payments increased from $102,796 to $176,561, or about 167%. *If this trend continues it will have a devastating impact on private hospitals.* Please, refer to Exhibit I

MEDICARE PART B

The Health Care Financing Administration provides payments to physicians based on a physician fee schedule, which is determined by three factors:

1. A nationally uniform relative value (RVU).
2. A Geographic Adjustment factor (GAF) for each physician fee schedule area.
3. Nationally uniform conversion factor (CF) for surgical, nonsurgical and anesthesia services.

The Geographic Adjustment Factor (GAF) for a fee schedule area is equal to a weighted average of the individual geographic practice cost indices (GPCI), for each of the three components of a physician's service.

1. Work (estimated value of physicians time)
2. Practice expenses and overhead (office rent supplies, equipment, staff salaries and fringe benefits)
3. Malpractice expense

These indexes are combined into a Geographic Adjustment Factor which determines the proportion of payment for a service provided in a particular region. Thus, the formula is:

RVU multiplied by GAF multiplied by CF = Payment

Technically, RVU factors for each of the three resources used in providing the specific service (work, practice expenses, malpractice) are multiplied by a corresponding GAF factor for each of the resources (and then added together) before being multiplied by the conversion factor.

Example

For HCPCS code 42182, Repair Palate, performed in Des Moined, Iowa, in 1993 you would multiply

(1) the work RVU by the work GAF (3.87 x 0.997=3.86),

(2) the practice expense RVU by the practice expense GAF (3.56 x 0.966=3.44), and

(3) the malpractice RVU by the malpractice GAF (0.39 x 0.666=0.26).

These three factors would be added together (7.56) and then, multiplied by the conversion factor for surgical service ($31.962 in 1993), which equals $241.63. Every physician performing this procedure in the Des Moines, Iowa area would be paid $241. 63 in 1993.

THIS SAME EXAMPLE IN PUERTO RICO WOULD BE AS FOLLOWS:

Example

For HCPCS code 42182, Repair Palate, performed in Puerto Rico, in 1993 you would multiply
(1) the work RVU by the GAF (3.87 x .882=3.41),
(2) the practice expense RVU by the practice expense GAF (3.56 x .763=2.72), and
(3) the malpractice RVU by the malpractice GAF (0.39 x 4.66=0.18),

Add them together (6.31) and multiply the sum by the conversion factor for surgical services ($31.962), which equals $201.68. *Every physician performing this procedure would be paid $201.68 in 1993, a difference of $39.95 (20%) less than Iowa.*

During the year 1994, Puerto Rico was the geographic region with the lowest payment rates. This was due to the fact that two of the three cost component index values for Puerto Rico were the lowest. During the year 1995, Puerto Rico is the geographic region with the lowest cost component.

**Puerto Rico's GPCIs Compared to Lowest Values
1994**

	Work	Practice Expense	Malpractice	GAF
Puerto Rico	0.882	0.763	0.466	0.813
Lowest in US	0.942 (Vermont)	0.838 (Mississippi)	0.407 (Tennessee)	0.886 (Arkansas)

**Puerto Rico's GPCIs Compared to Lowest Values
1995**

	Work	Practice Expense	Malpractice	GAF
Puerto Rico	0.883	0.739	0.268	0.794
Lowest in US	0.936 (S. Dakota)	0.809 (Missouri)	0.349 (Indiana)	0.880 (S. Dakota)

According to a study prepared by Lewin - VHI, a health policy and research firm, *it was determined that the assumptions and / or proxy measures, used to determine the GPCIs, were questionable in the case of Puerto Rico* due to the significant differences between the economy of Puerto Rico and that of the United States mainland.

FOLLOWING ARE THE MAJOR FINDINGS OF THE LEWIN-VHI STUDY

1. HCFA does not estimate the value of physicians' time directly (i.e., by measuring physician wages.). Rather, it uses an index created from the average hourly earnings of a sample of "professional" workers (including engineers, lawyers, teachers, and others) to capture regional variations in the value of physicians' time. Differences between the economy of Puerto Rico and that of the typical mainland location make the relative earnings of professional workers an inappropriate proxy for the relative opportunity cost of physicians' time in Puerto Rico.
2. HCFA does not measure physician office rents directly. Rather, it uses a Housing and Urban Development (HUD) *index of residential apartment rent to capture regional variations in physician office rent expenses.* The assumptions underlying this proxy measure are not satisfied in the case of Puerto Rico because of a multi-tiered real estate market.
3. HCFA does not take into account the higher shipping and handling costs for medical supplies and equipment incurred by physicians in Puerto Rico.
4. HCFA's survey of malpractice liability insurers found that nominal malpractice premiums in Puerto Rico did not change from 1986 to 1992.

CONCLUSION

In conclusion, the lowest labor and nonlabor components, wage index, geographic adjustment factor and federal capital rate does not necessarily mean these are incorrect. Puerto Rico is and should be a region with lower figures. *However, we consider HCFA has combined incorrect data and inappropriate assumptions which have significantly reduced the rates and figures drastically in the case of Puerto Rico.*

In the case of physicians payments, for example, many of the measurements made by HCFA in the calculation of practice expense are not direct measures of actual expenses, but indirect proxy measures. The validity of these proxy measures rest, in many instances, on assumptions that are inappropriate in the case of Puerto Rico.

In connection with the DRG formula applied to Puerto Rico, the fact that it has been static since October 1, 1987 (75/25), is a factor having a substantial impact on the financial stability of the hospital reimbursed under PPS/DRG located in Puerto Rico.

Five years after the implementation of PPS/DRG, there is a general consensus in the health care industry in Puerto Rico that the frozen formula imposed by the law has resulted in an unfair reimbursement, forcing the hospitals to reevaluate their financial capacity to maintain high quality of services needed by Medicare beneficiaries. Hospitals in Puerto Rico claim that they have been under pressure to operate with less than the required funds as a result of the blended rate. However, they also have to comply with requirements similar to those on the mainland to qualify for reimbursement. The result is that a substantial number of hospitals in Puerto Rico is either under financial difficulties, or is already operating under the provisions of the Bankruptcy Act.

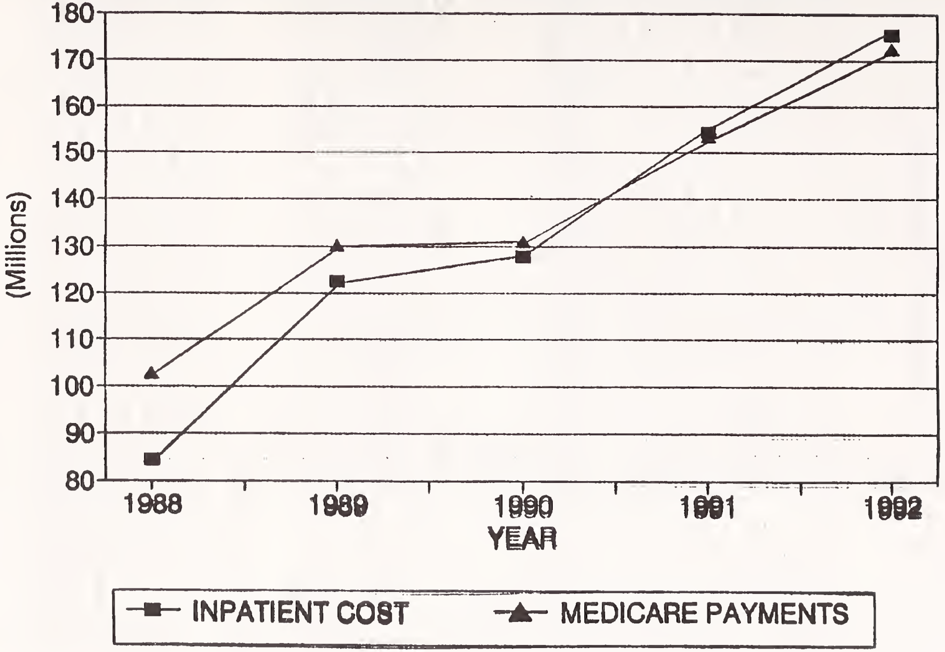
It is obvious that the overall objective of the general formula - which was to promote a strategy towards implementing cost containment measures by awarding incentives for efficiency - was not to force hospitals into a bankruptcy setting.

In Puerto Rico, the private medical plans do not take any more shifts from the Medicare program. Therefore, the continuous underpayment to hospitals may eventually affect the health care services to all patients as hospitals will be deprived of the funds necessary to maintain themselves as technically competent institutions and may not have the capacity to replace their equipment or to invest in more advanced technology. ***That is why a second look at the Medicare formulas both for hospitals and physicians and its components is required.***

EXHIBIT I

PRIVATE HOSPITALS

INPATIENT COST & MEDICARE PAYMENTS



Testimony of Valeriano Alicea-Cruz, M.D.
President, Puerto Rico Medical Association

Before the Subcommittee on Health
of the
Committee on Ways and Means

February 1995

Introduction:

Thank you, Mr. Chairman, for the opportunity to testify before your committee on behalf of the physicians of the Commonwealth of Puerto Rico. As you know, the Health Care Financing Administration adjusts Medicare Part B payments to physicians across the United States and its possessions based on its estimate of the geographic variation in physician practice expenses. Those areas where practice costs are estimated to be relatively higher receive a higher payment, while those areas with costs estimated to be relatively lower receive lower Part B payments for the same services. Bureaucratic costs would be meaningfully diminish if an universal formula is applied nationwide instead off regionally. You may not know that, based on these geographic cost adjustments, physicians in Puerto Rico receive the lowest Medicare Part B payments of all physicians receiving payments. Moreover, these payments are substantially lower than those received by physicians in the next lowest geographic area defined by HCFA.

How GPCI's Are Computed:

HCFA computes indexes, called Geographic Practice Cost Indices (GPCIs), for each of the three components of physician payments: (1) the "work" GPCI, which estimates the value of the physician's time; (2) the practice expense GPCI, which includes the cost of office rent, supplies, equipment and staff; and (3) malpractice expense. HCFA combines these indexes into a "Geographic Adjustment Factor" (GAF). The GAF determines the proportion of a full Medicare payment for services that physicians in a particular geographic region are paid. The average GAF across all regions is 1.0. If the factor is 0.9 in a particular region, physician in that region receive 90% of the average Medicare Part B payment.

Discriminatory Situation:

Reduced Medicare payments adversely affect the incomes of physicians and health care workers in Puerto Rico. However, Medicare Part B reimbursements to physicians in Puerto Rico are, in the long run, not merely a matter of the incomes of physicians and the incomes of other health care workers. A policy which, in effect, consistently reimburses Puerto Rico's physicians at lower rates than physicians in other geographic regions for the same services, when those lower reimbursement rates do not properly reflect underlying cost differences, will eventually result in fewer physicians and less access to health care for the people of Puerto Rico. This will adversely affect the welfare of both Medicare and non-Medicare patients in Puerto Rico.

Comparison of 1994 and Estimated 1996 GPCI's:

In 1994, physicians in Puerto Rico received about 81% of the average payment that physician received for a given medical service. This was the lowest payment rate of all the geographic regions defined by HCFA. Physicians in the next lowest region received payments almost 9% higher than those received by physicians in Puerto Rico. Two of the three cost component index values for Puerto Rico, as estimated by HCFA, were the lowest of all regions.

Under recent HCFA revisions to GPCIs, Puerto Rico will have the lowest reported value for all three components. The 1996 GAF for Puerto Rico of 0.79 means that our physicians will receive payments that are 21% lower than the payments received by the typical physician for the same services. The next lowest region will receive payments fully 11% higher than Puerto Rico. **Table 1**, included for the record, illustrates these points.

Table 1.
Puerto Rico's GPCIs Compared to Lowest Values: 1994 and 1996.

	Work[1]	Practice Expense	Malpractice	GAF
		1994 GPCIs		
Puerto Rico	0.882	0.763	0.466	0.813
Lowest (next lowest, if lowest is Puerto Rico)	0.942 (Vermont)	0.838 (rest of Mississippi)	0.407 (Tennessee)	0.886 (Arkansas)
		1996 GPCIs		
Puerto Rico	0.883	0.739	0.268	0.794
Next Lowest	0.936 (S. Dakota)	0.809 (small cities in Eastern Missouri)	0.345 (urban/rest of Indiana)	0.880 (S. Dakota)

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[1] The work GPCI reflects only 25% of the difference between the measured value of physicians' time and the national average. Hence, a work GPCI of 0.883 represents a measured index value of about 0.526.

We recognize that having the lowest value for the payment adjustment index does not necessarily mean that it is incorrect or that physicians in Puerto Rico are being treated unfairly. In any such calculations, some region will necessarily be the lowest.

However, many of the measurements made by HCFA in the calculation of practice costs are not direct measure of actual expenses, but indirect proxy measures. The validity of these proxy measures rests, in many instances, on assumptions that we believe are inappropriate for the case of Puerto Rico. Because of important differences between the economy of Puerto Rico and the typical mainland economy, the relationship between these proxy variables and the true practice expense is likely to be significantly different in Puerto Rico compared to the economies of regions in the U.S.

Findings and Recommendations, study by Lewin-VHI, Inc.

Lewin-VHI, Inc., a health policy and research firm, has reviewed the calculation of the GPCIs and the assumptions underlying them for Puerto Rico, at our request. Their analysis incorporates data from a variety of sources including a special survey, conducted as part of this project, of approximately 200 Puerto Rico physicians. Four areas were found in which the indexes are based on assumptions and/or proxy measures which, due to significant differences between the economy of Puerto Rico and that of the US mainland, are questionable for the case of Puerto Rico. The following are the major findings and recommendations, which we cite directly from the Lewin-VHI, Inc. study:

- Overall, the methodology used by HCFA is reasonable, given both the practical constraints on available data and the theoretical difficulties inherent in computing the indexes. However, many of the assumptions deemed reasonable for the mainland U.S. do not hold in the case of Puerto Rico.

- HCFA does not estimate the **value of physicians' time** directly (i.e., by measuring physician wages). Rather, it uses an index created from the average hourly earning of a sample of "professional" workers (including engineers, lawyers, teachers, and others) to capture regional variations in the value of physicians' time. Differences between the economy of Puerto Rico and that of the typical mainland location make the relative earnings of professional workers an inappropriate proxy for the relative opportunity cost of physicians' time in Puerto Rico. As an alternative, physician earnings are measured directly for Puerto Rico, adjusting the potential dependency of earnings on Medicare payments, and compared to that of US physicians. Based on a direct comparison of physician wages, HCFA should raise Puerto Rico's work GPCI value from 0.883 to 0.924, and increase the overall Geographic Adjustment Factor for Puerto Rico by 0.022, a 2.77 percent increase.

- HCFA does not measure **physician office rents** directly. Rather, it uses a Housing and Urban Development (HUD) index of residential apartment rent to capture regional variations in physician office rent expenses. The assumptions underlying this proxy measure are not satisfied in the case of Puerto Rico because of the degree to which rents are subsidized in Puerto Rico, and because of a multi-tiered real estate market. Three alternative measures of rental costs indicate that, when controlling for quality, office rental prices in Puerto Rico approximate the U.S. national average. By making this adjustment, Puerto Rico's GAF will rise by approximately 3.2 percent.

- HCFA does not take into account the **higher shipping costs** for medical supplies and equipment incurred by physicians in Puerto Rico. Data from shipping companies indicate that medical supplies and equipment are more expensive to ship from the U.S. mainland to Puerto Rico than within the mainland. Estimates indicate that if HCFA adjusts Medicare reimbursement rates to account for these additional shipping costs, Puerto Rico's GAF will rise approximately 0.02 percent.

- HCFA's survey of **malpractice liability** insurers found that nominal malpractice premiums in Puerto Rico did not change from 1986 to 1992. The survey of physicians in Puerto Rico conducted for this study indicate that from 1989 to 1993, malpractice insurance premiums rose at an average annual rate of 5.9 percent. After adjusting HCFA's estimate to account for this premium growth, Puerto Rico's GAF will rise by approximately 0.2 percent due to this factor.

The effect of these recommended changes on the Geographic Adjustment Factor for Puerto Rico is summarized in the following table.

Table 2.
Proposed Index Values and Revised GAF for Puerto Rico

Index	Original Index	New Index
Physician Work GPCI	0.883	0.924
Practice Expense GPCI:		
--Nonphysician Payroll Index	0.499	0.499
--Rent Index	0.752	1.00
--Supplies, Equipment, Miscellaneous Other Index	1.00	1.01
Malpractice GPCI	0.268	0.30
GAF	**0.794**	**0.845**

Conclusion

Based on these recommended changes, the GAF for Puerto Rico would **increase by 6.4%.** The GAF computed for Puerto Rico would remain the lowest of all geographic locations, as would the individual GPCIs. The effect of these changes on the national average is negligible.

We have suggested that the assumptions underlying the lower payment rates for Puerto Rico are, in several instances, inappropriate, and have adjusted the practice cost indexes using other data sources. If we apply the revised GAF for Puerto Rico to projections of its 1995 and 1996 Medicare Part B payments, we estimate that Medicare payments to providers in Puerto Rico would increase by approximately $11 million in 1995 and $23 million in 1996, in nominal dollars, over what they would have been under the original GAF.

Adjustment of Medicare Part B payments to reflect geographic differences in practice expense is reasonable. However, the methods and data used by HCFA to make these adjustments are less than ideal. In the case of the Commonwealth of Puerto Rico, the assumptions underlying the proxy measures used to make adjustments to Medicare Part B payments, including the structure of wages among the professions and the market for office space, must be carefully evaluated. Errors that consistently understate practice expenses in Puerto Rico compared to the other localities are not only unfair to the physicians and health care workers in the Commonwealth of Puerto Rico but, in the longer run, to all the users of the health care system.

Thank you, Mr. Chairman.

STATEMENT OF COLONEL FRANK G. ROHRBOUGH, USAF RETIRED
DEPUTY DIRECTOR OF GOVERNMENT RELATIONS
THE RETIRED OFFICERS ASSOCIATION

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE

This statement is submitted on behalf of The Retired Officers Association (TROA), which has its national headquarters at 201 North Washington Street, Alexandria, Virginia. TROA has a membership of more than 400,000 active duty, retired, and reserve officers of the seven uniformed services. Included in its membership are approximately 65,000 auxiliary members who are survivors of former members of the association.

On behalf of TROA's members, we would like to thank the Chairman and other distinguished members of the House Ways and Means Committee's Subcommittee on Health for allowing us to submit our recommendations for the enactment of an innovative concept for reducing Medicare costs.

INTRODUCTION

Health care has always been regarded as the most important benefit, after military retired pay, for our members. Based on membership surveys, we know that many TROA members prefer Department of Defense (DoD) military hospitals as their primary source of health care. Over 90 percent of TROA members who use military medical facilities (MTFs) report they were satisfied or very satisfied with the quality of the health care they received. The quality of health care in military hospitals is further documented by the Joint Commission on Accreditation of Healthcare Organizations. Its survey results indicate that military hospitals generally perform better than most of their civilian community hospital counterparts.

While quality of care in MTFs is judged as good, the availability of care has become increasingly uncertain, and inaccessible in many cases, forcing many, if not most, older retirees to seek health care in the private sector. This has imposed significant difficulties for retired families in many communities because many civilian providers already refuse to participate in the Medicare program.

We applaud the efforts underway in Congress to make Medicare more cost-effective and to constrain its growing cost. Nevertheless, TROA is gravely concerned that further cuts to Medicare providers will mean fewer providers participating in Medicare, a further shifting of the cost of care to private insurers and citizens and - inevitably - rationing of care for the elderly.

THE OBSTACLES TO COST-EFFECTIVE CARE FOR THE DEPARTMENT OF DEFENSE

Approximately 70 percent of TROA's members get their health care from civilian sources, primarily on a "fee-for-service" basis through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Medicare. While "fee-for-service" gives individuals greater freedom to choose their own provider, it is generally more costly to them and the government. Responding to a national trend, many of our members are turning to managed care plans to assure access to comprehensive care. For example, more than 4,500 Medicare-eligible military retirees and spouses in San Antonio, Texas are enrolled in PacifiCare's "Secure Horizons" Medicare health maintenance organization (HMO) plan. Retirees are selecting such alternative plans, despite the availability of two major military medical teaching centers in town, because Secure Horizons contains two ingredients that are missing from the Military Health Services System (MHSS) -- continuity of care and assured access to quality health care services.

Although many of our members express strong interest in joining DoD's new "Tricare Prime" -- a managed care program which has been mandated by Congress and is to be fully operational by 1997-- an extremely serious obstacle exists: **Under current law, DoD cannot be reimbursed for Medicare-eligible retirees who would like to enroll, which effectively bars all older military retired beneficiaries from using it**. Lacking Medicare reimbursement, DoD has no funding or financial incentive to treat military Medicare eligibles, thus **they are being shoved out of the military health care system and onto Medicare.** If that were not bad enough, CHAMPUS-eligible beneficiaries who enroll are abruptly disenfranchised from Tricare when they become Medicare-eligible. Theoretically, Medicare-eligible retirees and their spouses could still be treated in military treatment facilities (MTFs) on a **"space-available" basis**. But, the truth is that MTF space available care will evaporate as enrollments in Tricare Prime grow and regional provider networks reach their full program capacity.

THE "MEDICARE SUBVENTION" IMPERATIVE

For some time, TROA and The Military Coalition - a consortium of 27 military and veteran organizations, representing 3.75 million members of the uniformed services (active, reserve and retired) plus their families and survivors - have advocated implementation of a reimbursement concept called "Medicare Subvention". Subvention means the Health Care Financing Administration (HCFA) would reimburse DoD for care provided to Medicare-eligible beneficiaries in military treatment facilities (MTFs). From a fiscal viewpoint, **subvention will save money both for the government and the taxpayers.** Equally important, **it will preserve military medical readiness, and keep faith with military beneficiaries who accepted repeated government promises of lifetime health care in return for their decades of career military service.**

Fiscal Considerations

In the past, Medicare has reaped an apparent windfall for every Medicare-eligible beneficiary treated in an MTF. DoD provided over $1 billion in "space available" care in MTFs in 1994 to about 230,000 Medicare-eligible military retirees. Thus, DoD has been subsidizing the Medicare Trust Fund, even though these beneficiaries have paid payroll taxes to the Hospital Insurance (HI) Fund all through their years of government employment. Not surprisingly, HCFA has been concerned that should subvention be authorized, Medicare outlays would immediately increase.

In reality, Medicare costs are going to increase even more if subvention is not authorized. The fact is that Tricare Prime will turn thousands of Medicare-eligible retirees away from military health care and force them to use Medicare in the private sector. This is already happening as military bases and MTFs are closed or downsized. The trend will only accelerate as Tricare is implemented across the country. By the end of 1997, DoD will treat only a tiny fraction of the Medicare-eligible retirees they see today. **Subvention is a cost-effective alternative for addressing this phenomenon**. DoD acknowledges that, if subvention is authorized, its medical budget could be decreased by an amount corresponding to the reimbursement received from Medicare. Last year, when the Senate and the House Armed Service Committees favorably reported subvention in their inputs to national health care reform, the Congressional Budget Office acknowledged this fact. Thus, enactment of subvention would be cost-neutral even under a worst-case scenario. That is, the increase in Medicare expenditures could be offset by a corresponding decrease in the DoD budget.

Subvention Ultimately Saves Money for the Government

However, the more likely scenario is that subvention would reduce the cost to the government, because DoD-provided health care would cost Medicare less than the same care provided in the private sector. To illustrate, a Medicare/military treatment facility pilot project, conducted at U.S. Naval Hospital, San Diego, between November 1988 and March 1990, demonstrated that the potential savings for HCFA are significant. Under this project, the Navy contracted with two private Medicare-certified physicians to perform inpatient and outpatient services at the military hospital for a negotiated fee. HCFA authorized the waiver of the Medicare co-payment and the Naval Hospital provided the facility at no cost to Medicare. Over the test period, 75 coronary artery bypass grafts were performed in the Naval Hospital at a conservatively estimated savings of $17,000 per procedure, generating a total savings of $1.3 million.

When such savings are possible, it is clear that maximum use should be made of MTFs. This is further supported by a 1990 GAO Study directed by the House Armed Services Committee. That report (GAO/HRD 90-131) concluded that DoD would reap substantial savings by adding staff and equipment at military hospitals to treat more patients rather than paying for their care under CHAMPUS.

Based on a review of six hospitals, GAO estimated savings ranging from $18 million to $21 million in CHAMPUS funds. If Medicare-eligible beneficiaries were included, the savings to the Government would be substantially greater. Such potential savings were further substantiated in DoD's "Section 733 Study of the Military Medical Care System" released in May 1994, which found that care could be delivered 10 to 24 percent less expensively in military treatment facilities. Thus, if MTF commanders were provided the wherewithal to compete with Medicare providers, they could expand the capability of their facilities, clinically challenge their providers, and better meet the needs of all DoD beneficiaries -- all while saving Medicare money.

It seems to us, if necessary, this Committee could lock-in these savings by stipulating in the law that the HCFA reimbursement to DoD will not exceed 95 percent of the amount Medicare would pay to a civilian Medicare HMO.

All the evidence clearly demonstrates that the current statutory constraints inhibit the system from operating at maximum efficiency. Such restrictions inhibit DoD's and HCFA's ability to cooperate in reducing government cost. It forces each into penny-wise and pound-foolish decisions that myopically subordinate the government interests to parochial budgetary considerations. Thus, DoD budget constraints force exclusion of Medicare-eligible retirees, even though that exclusion will increase overall costs to the government. At this juncture, DoD has developed legislation, pending OMB clearance, which will permit MHSS facilities to receive Medicare reimbursement so they can compete with civilian sector Medicare "At Risk" HMOs.

We believe that subvention would facilitate maximum use of federal medical facilities and at the same time reduce the Governments outlays for health care.

Retention And Readiness Concerns

While the cost issue is extremely significant, there is yet another reason why exclusion of retired personnel from the military health care system undermines the government's long-term interests. That reason is that such actions undermine the very purpose of the Department of Defense -- to ensure the Nation's military forces are prepared and ready to defend the National interest, by force if necessary.

A crucial aspect of this issue is personnel readiness, which is totally dependent on sustaining strong incentives for high quality personnel to continue to serve full military careers comprising 20 to 30 years of arduous service and sacrifice. Well-documented historical "offers of lifetime health care benefits" were one of the primary incentives that induced many current retired members to serve military careers that often spanned two or three wars. Now, they are understandably shaken at the prospect of being foreclosed from any access to the military health care system. Finding themselves left with no coverage but Medicare -- at a time when the government seems bent on drastic reductions in Medicare benefits -- many are understandably bitter at being treated as if their decades of service and all of the government's past promises have no value. Such sentiments bode extremely ill for long-term retention and readiness.

Any employer dependent on internal promotion for its mid-level and senior management must keep the promises it makes to its employees. Such credibility is doubly important when the employer is the United States government, and the employees are military members whose conditions of service include extended family separations, forfeiture of many personal liberties and repeated hazards to life and limb. To induce members to serve 20 or 30 years under such conditions, the government must offer -- and has offered -- an exceptionally attractive benefits package. **The prospect now is that, after the members have been induced to serve, and after they have attained an age when their medical benefits have assumed major importance in their lives, they are to be closed out of the military health care system and left with no employer provided health benefits at all. Just Medicare.**

Mr. Chairman, General Motors subsidizes supplemental health care for its Medicare-eligible retired employees. The Federal government provides supplemental coverage to Medicare under the Federal Employees Health Benefits Program to every Federal civilian employee. Supplemental coverage is provided to Medicare-eligible retired Members of Congress and their families. Supplemental coverage is provided to retired Congressional staffers and their families. Yet, implementation of the Tricare system under current law denies any such "employer-provided" health care benefits to those 65 and older who fought their country's battles -- or to the survivors of those who died in the Nation's defense while believing that the government would keep its promises in this matter.

The treatment of today's retirees will not be lost on today's active duty military members. Unless Congressional and Government leaders meet their commitments and responsibilities for today's retirees, military commanders' retention promises to the current force will ring hollow. The incentives to endure the well-known sacrifices inherent in a military career will be significantly diminished, and retention and readiness will inevitably suffer.

There is one final, but critical readiness consideration which deserves comment. **Ensuring Medicare-eligibles access to the military health care system will also help ensure we maintain a military medical force that will be prepared for any operational contingency.** To be prepared to accomplish DoD's wartime and contingency missions, medical personnel must be recruited, trained and retained. Their retention is contingent on professional advancement which means they must see and treat a wide range of patients and with a broad spectrum of medical problems. Medicare-eligible retirees provide that clinical experience. By having well-trained, quality physicians and allied health care providers, the medical community is better able to respond to any military contingency operation or wartime deployment which this nation may face in this very unstable world. Military deployments to Haiti, Somalia and Bosnia are excellent examples of how treating a wide range of clinical conditions prepares military medical personnel for military contingencies.

TROA'S POSITION

Mr. Chairman, the Nation has an obligation to do better. It has an obligation not only to those who have already served, but also to those who are now serving, and to the current and future generations of Americans who require a strong national defense to preserve them from the continuing threats of a dangerous world. This is a matter not only of keeping promises and doing the right thing by those who have served; it is a matter of acting in the national interest.

TROA is convinced that military medical readiness will suffer if Medicare-eligible retirees and their spouses are denied access to care in the military health system. The system must attract, train and retain physicians and other health care personnel if it is going to be a capable and viable national resource for the defense of this great country. Medicare subvention will provide that institutional foundation which is needed to meet any contingency operation and will insure that military retirees will have the freedom of choice in health care they have earned and deserve.

Unless dramatic changes are forthcoming, Medicare-eligibles' access to health care providers will be so restricted as to deny them access to care when they increasingly need it. The use of Medicare "risk contracts" to provide health care services on a capitated basis, as now used by HCFA, has great potential, if similar risks were assumed by DoD. The bottom line is that subvention will save money for everyone -- Medicare, DoD, patients and taxpayers. **We, therefore, strongly recommend that this committee favorably report the subvention provisions contained in H.R. 580, which was introduced by Representative Joel Hefley (R-CO) on January 19, 1995.**

CLOSING

Mr. Chairman, thank you for allowing us the opportunity to present the views of The Retired Officers Association on this very important issue. Any questions that you or any other members of the Committee might have can be referred to us at the National Headquarters.

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SUN Home Health Services, Inc.
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MAIN OFFICE:
61 Duke Street, PO Box 232
Northumberland, PA 17857
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BRANCH OFFICES:
[illegible]

[illegible] • 717 374 [illegible]
[illegible] • 717 [illegible]

February 6, 1995

Mr. Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
U S House of Representatives
1102 Longworth House Office Building
Washington DC 20515

Dear Mr. Moseley:

Written Testimony for February 6, 1995, Committee on Ways and Means hearing regarding growth in Medicare.

For the last 13 plus years, I have been the Chief Financial Officer of the largest home care provider in Central Pennsylvania. I have seen and experienced first hand the significant expansion of home care services and the corresponding benefit to the community we serve.

Skilled home health services have become an integral part of our nations health care delivery system. Home health agencies have allowed the DRG payment system to work for hospitals as patients have been discharged earlier to the less expensive alternative of home care services. We, as a nation, have benefited greatly by the expansion of home care services that allows chronic and acute care patients to complete their recovery at home.

As we explore the perceived problems, let us not be hasty to undo the success of the past. The Advisory released by the Committee on Ways and Means suggests in the background that program growth "may represent significant fraud and abuse." It is clear that a small percentage of home care providers do undoubtedly act in a fraudulent way. It is also clear that the present home health reimbursement system is such that fraudulent providers are hard to identify and even harder to prosecute.

The current system not only allows two provider to get paid different prices for the same service but allows providers to get varying number of visits paid for an equal situation.

The answer is not co-payments or co-insurances. The answer is a total overhaul of the payment system to include incentives for providers to provide cost-effective quality care.

I would encourage the Congress to put away the Band-Aids and perform the surgery that is necessary. It is time to develop a fair and reasonable prospective payment system that will control costs, benefit providers and meet the needs of the millions of Americans needing home care services.

Sincerely,

Steven Richard

Steven Richard
Chief Financial Officer

[illegible] COMMISSION [illegible] ACCREDITATION OF HEALTHCARE ORGANIZATIONS
[illegible] Northumberland County, [illegible] County, [illegible] County, Central Susquehanna Valley and Mifflin-Juniata Counties United Ways

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